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ABSTRACT

The American Hospital Association's Commission on Workforce for Hospitals and Health Systems identified the workforce development related challenges facing health care institutions and issued a series of recommendations regarding how hospital leaders can build a thriving workforce. The change strategies identified by the commission were as follows: (1) foster meaningful work by transforming hospitals into modern-day organizations in which all aspects of work are designed around patients and the needs of staff to care for and support patients; (2) improve the workplace partnership by creating a culture in which hospital staff are valued, have a sustained voice in shaping institutional policies, and receive appropriate rewards and recognition for their efforts; (3) broaden the base of health care workers by designing strategies that attract and retain a diverse workforce of men and women, racial and ethnic minorities and immigrants, and older workers; (4) collaborate with others to attract new entrants to the health professions; and (5) build societal support for the public policies and resources needed to help hospitals hire and retain a qualified workforce. (Thirty-six strategic recommendations, 112 tactical recommendations, and 22 tables/figures/boxes are included. The following items are appended: the commission's charge; commissioner biographies; and lists of historically Black colleges and universities and Hispanic-serving institutions.) (MN)

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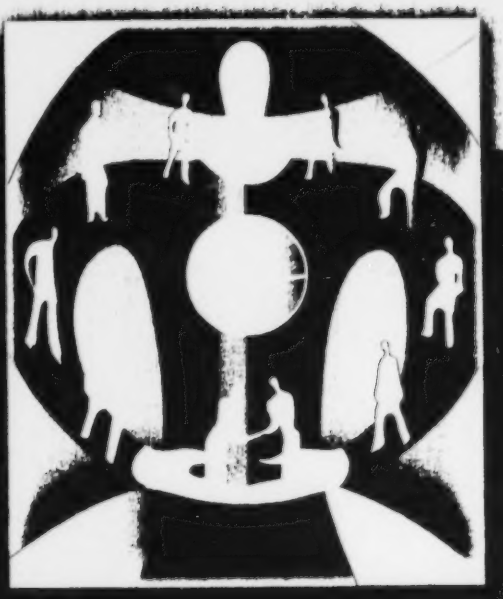

In Our Hands

HOW HOSPITAL LEADERS CAN BUILD A THRIVING WORKFORCE

AHA Commission on Workforce for Hospitals and Health Systems

April 2002

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Acknowledgements

The Commission has benefited from the dedicated and personal commitment of its individual members who represent a broad cross-section of those concerned about this important topic and from the tireless efforts of its staff from the American Hospital Association. We are hopeful the resulting report will make a difference in achieving a high quality health care workforce for the future.

The Commission would like to acknowledge and thank the following individuals for their participation and significant contributions to the Commission's deliberations: U.S. Secretary of Education Rod Paige; David Stum, President of Aon's Loyalty Institute; Doug Michels, President of J & J Health Care Systems, Inc.; Robert Mosbacher, Chairman of the Board of Methodist Hospital, Houston; the American Society for Healthcare Human Resources Administration Board of Directors; and the American Organization of Nurse Executives Board of Directors.

In addition to the staff listed in the report, the Commission wishes to recognize the additional AHA staff who provided essential assistance in the development and publication of this report: Elisa Arespacochaga, Sara Beazley, Yvonne Blackburn, Robyn Cooke, Susan Edge-Gumbel, Mary Grayson, Jim Reiter, Dianne Spenner, Alden Solovy, Jennifer Towne, Delores Wade, and Martin Weitzel.

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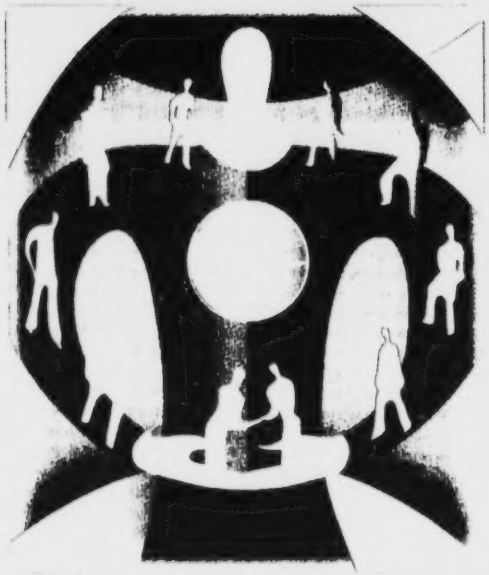

In Our Hands

HOW HOSPITAL LEADERS CAN BUILD A THRIVING WORKFORCE

AHA Commission on Workforce for Hospitals and Health Systems

April 2002

AMERICAN HOSPITAL ASSOCIATION
FOUNDED 1898

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A Letter to the Reader

April 8, 2002

To the reader:

Among the many issues facing the field of health care, none is more important to its long-term future than solving the growing workforce crisis. Fundamentally, good health care is people caring for people. Plus, good hospital care is numerous caregivers in a variety of occupations providing services to patients on an individual, highly personalized basis. The provision of that care is made possible by workers in many fields who support the systems and resources that sustain both patients and caregivers. The work is demanding, but can and should be equally rewarding, because everyone in the hospital is helping to meet a vital human and community need.

Yet, as this report documents, hospitals face a severe shortage of workers that threatens their ability to meet community needs. It is a long-term shortage that is much broader and more severe than the periodic shortages that have been experienced at various times over the past four decades. This current shortage reflects growing demand, shifting demographics, a change in career expectations and attitudes about work, and worker dissatisfaction within health care.

If the shortage is not solved, it is certain to result in a major national health care crisis.

While society has significant responsibility for dealing with this crisis, this report—IN OUR HANDS—recommends bold, innovative changes that hospitals and their leaders must make in order to avert limitations in necessary health care services now and in the future. The report also contains recommendations for others, such as government, which are critical to support the actions of hospital leaders.

The report is organized into an introduction (*A Looming Crisis in Care*) and five chapters:

- **FOSTER MEANINGFUL WORK**
- **IMPROVE THE WORKPLACE PARTNERSHIP**
- **BROADEN THE BASE**
- **COLLABORATE WITH OTHERS**
- **BUILD SOCIETAL SUPPORT**

Each chapter contains strategic recommendations and specific tactical recommendations. The report also includes a Workforce Strategy Map at the end that provides an overview of the recommendations. The report begins with an executive summary that highlights the essential principles that underlie both the strategic and tactical recommendations and ends with a summary of the Commission's fundamental conclusions about the workforce crisis, appendices and an index.[1]

IN OUR HANDS presents the basic conclusion of the AHA Commission on Workforce for Hospitals and Health Systems: hospital leaders, including management, trustees, physicians, and others who have the ability to influence the direction of these recommendations, have the primary responsibility for making the changes necessary to attract and retain caregivers and support staff. Others in society, including government, business, and the public at large, have a responsibility to make the supportive and complementary changes that can ensure hospitals' success in this crucial effort.

The Commission believes that bold and innovative action is needed now to ensure a long-term supply of qualified, compassionate, enthusiastic, and satisfied workers for hospitals and the communities they serve. The Commission urges hospitals, associations, schools and universities, foundations, businesses, and government to study the recommendations in this report ... and then act on them.

It's a job we must do together for our communities, for our nation, for our health.

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[1] Appendices are included for:
- The Commission's Charge
- Commissioner Biographies
- Historically Black Colleges and Universities
- Hispanic Serving Institutions

[2] Mr. Mecklenburg chaired the Commission from November 2001 to April 2002.

[3] Mr. Butler chaired the Commission from April 2001 to November 2001.

Executive Summary

Hospitals today face both an immediate need for caregivers and support staff and an even more threatening long-term shortage of qualified workers. The current shortage mirrors many of the characteristics of the workforce shortages hospitals have faced in the past. But this shortage is different because it is the prelude to a long-term shortage that results from four significant demographic and societal trends:

- The U.S. labor force is aging,
- There are fewer potential workers coming behind the aging "baby boomer" generation,
- Careers in health care are seen as less attractive to those entering employment, and
- Many in the current hospital workforce are dissatisfied with their work.

With the demand for hospital services increasing because of a growing and aging population, the workforce shortages facing hospitals present our nation with a potential health care crisis.

The AHA Commission on Workforce for Hospitals and Health Systems believes strong leadership and aggressive action is needed to address the workforce shortage, build a thriving workforce, and avoid a crisis in care. The Commission believes it is hospital leaders—especially boards of trustees and hospital executives—who must address numerous challenges to overcome the shortages. Thus the report is entitled **IN OUR HANDS**.

Some of these workforce challenges are within the hospital and some involve building partnerships with others. To encourage action, the report makes strategic and tactical recommendations for addressing the challenges and offers examples of hospitals already implementing the recommendations. It is hoped that the combination of clearly stated challenges, recommendations, and examples will serve as a catalyst to reduce substantially the current shortages and prevent the developing one.

The recommendations of the AHA Workforce Commission are presented in five chapters, each reflecting a key to solving the workforce crisis in hospitals and health systems:

1 **Foster meaningful work** by transforming hospitals into modern day organizations in which all aspects of the work are designed around patients and the needs of staff to care for and support them. Workers must find meaning in their work and be supported in their efforts to provide high-quality patient care.

2 **Improve the workplace partnership** by creating a culture in which hospital staff – including clinical, support, and managerial staff – are valued, have a sustained voice in shaping institutional policies, and receive appropriate rewards and recognition for their efforts.

3 **Broaden the base** of health care workers by designing strategies that attract and retain a diverse workforce of men and women, racial and ethnic minorities and immigrants, and older workers.

4 **Collaborate with others** — hospitals, health care and professional associations, educational institutions, corporations, philanthropic organizations, and government to attract new entrants to the health professions.

5 **Build societal support** for the public policies and resources needed to help hospitals hire and retain a qualified workforce, including adequate payment rates for hospital care; financial support for the introduction of information technology that facilitates improvements in the way hospital work gets done; and regulatory reform that reduces administrative burdens and promotes effective team approaches to providing quality care.

A Looming Crisis in Care

Hospitals[1] are busy places. In 2000, they cared for:

- 35 million admissions,
- 592 million outpatient and emergency visits, and
- 4 million births.[2]

While the care of these patients takes place in hospital buildings with state-of-the-art equipment, it is a large number of hospital staff who provide the care, keep the buildings running, and operate the equipment.

Fundamentally, hospitals are about people caring for people. In 2000, hospitals had 4.5 million full-time-equivalent employees, including caregivers[3] and support personnel[4]. In addition, there are hundreds of thousands of physicians, volunteers, and auxillians who work in hospitals.

Hospital workers are special people who are always there to respond when patients are at their most vulnerable. Society expects hospital workers to maintain the highest qualifications and to act selflessly, placing the best interests of the patient above all else. This is a unique public trust, one that should result in society placing a high value on all hospital workers. Unfortunately, compensation, schedules, and working conditions often do not support community expectations.

TWO WORKFORCE SHORTAGES

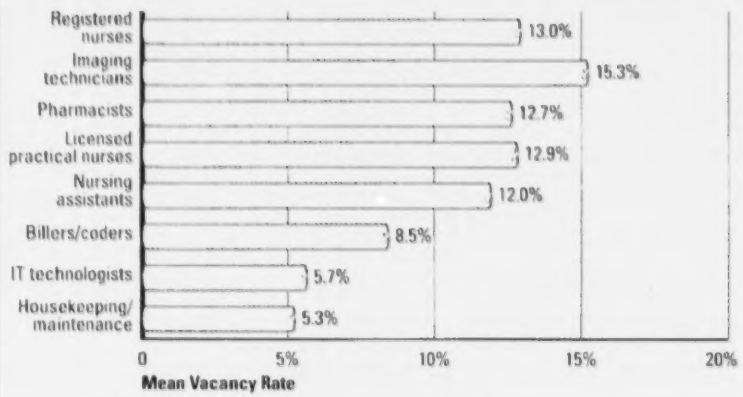
Today, hospitals face two workforce shortages: an immediate need for workers across many job classes, and an even more threatening long-term shortage of qualified staff at the same time that demand for hospital services is growing rapidly. The current shortage is pervasive and growing:

- 89 percent of hospital CEOs are reporting significant workforce shortages.[5]
- Shortages are being reported in nearly every type of hospital job. When hospital CEOs were asked, "what are the job categories in which you are experiencing the greatest workforce shortage?"[6] they responded affirmatively as follows:

Job Categories in Which Hospitals Are Experiencing Workforce Shortages

Registered nurse	84%
Radiology/nuclear imaging	71%
Pharmacy	46%
Lab/medical technology	27%
Nursing/clinical aides	20%
Physical/occupational/ speech therapy	11%
Housekeeping/maintenance	10%
Respiratory therapy	10%
Billing/coding	8%
Information systems	7%
Entry level (general)	7%
Dietary/food service	7%
Surgical	6%
Medical records/transcription	5%
Physicians	5%

Hospital Vacancy Rates — Fall 2001



1 The U.S. labor force is aging.

Median Years of Age of the U.S. Labor Force[8]

Year	Median Age of Labor Force
1978	34.8 years
1988	35.9
1998	38.7
2008	40.7

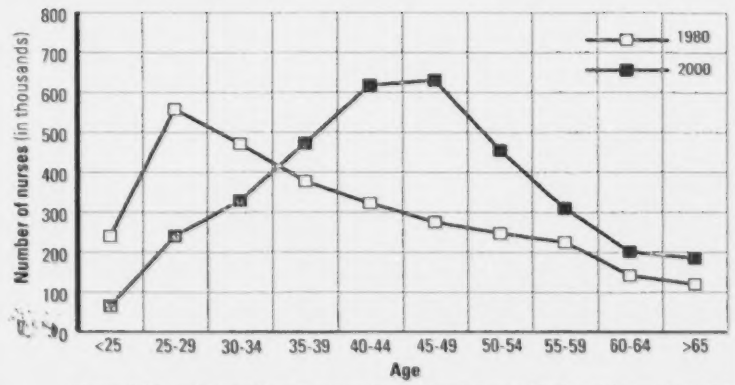
The reported shortages are significant, as shown above by hospital vacancy rates reported in the fall of 2001.[7]

In recent decades, hospitals have experienced periodic shortages of workers, especially nurses. In strong economic times, some people, especially working mothers, chose to work part-time, while others took advantage of the high demand for labor to explore new careers. But when the economy weakened and family finances destabilized, the attractiveness of working in hospitals increased and workforce shortages declined.

However, a slow economy will not eliminate either the current or projected shortages of hospital workers because of an underlying, long-term structural shortage that is being caused by the convergence of four significant demographic and societal trends.

Health is not immune from this trend and may be even worse off. For example, as the chart below demonstrates, in the past 20 years, the average age of a nurse has increased dramatically, and in 2000 it was 47 years.

Age Distribution of the Registered Nurse Population, 1980 and 2000



Source: HRSA, the Registerd Nurse Population: National Sample Survey of Registered Nurses, March 2000

2. **The U.S. workforce is growing much more slowly than in past decades. There are fewer potential workers coming behind the aging "baby boom" generation.**[9]

Annual Rates of Labor Force Growth, 1950-2025

Time Period	Labor Force Growth
1950-1960	1.1%
1960-1970	1.7%
1970-1980	2.6%
1980-1990	1.6%
1990-2000	1.2%
2000-2015	1.0%
2015-2025	0.2%

3. **Today, health careers are perceived as less attractive for a number of reasons:**[10]

- In a manufacturing economy, health care was seen as high tech; in today's information economy, young people see health care as low tech.
- In the 1960s and '70s, health care was safe, secure, and prestigious employment; in today's labor market, health care is seen as chaotic and unstable.
- In a traditional society, health care was one of only a few employment options for women; in contemporary society, health care is one of many choices.
- In a long-stay hospital system, staff had strong, supportive relationships with patients; in a short-stay hospital system, staff are focused on disease protocols, regulatory compliance, and documentation.
- In a mass-production society, when production schedules controlled work hours, the 24 hours a day, 7 days a week demands of hospitals were seen as merely unattractive; in an information society where people schedule work to their own convenience, the 24/7 demands of hospitals are seen as unacceptable. The impact of 24/7 is heightened by the presence of short-stay, high-acuity patients who place continuous demands on hospital staff for care and support.

4. **Too many people in the current hospital workforce are dissatisfied.**

Most health care workers entered their professions to "make a difference" through personal interaction with people in need. Today, many in direct patient care feel tired and burned-out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment. They feel they have no way to change the situation. Some have decided to exit the hospital setting, while others are telling their friends and children not to go into health care careers.

The Commission believes these trends foreshadow an ever-increasing workforce shortage unless hospital leaders act now to become employers of choice. An adequate supply of qualified workers is an essential component of any hospital's critical success factors. A comprehensive and effective strategic human resources plan is as important to success as sound financial planning.

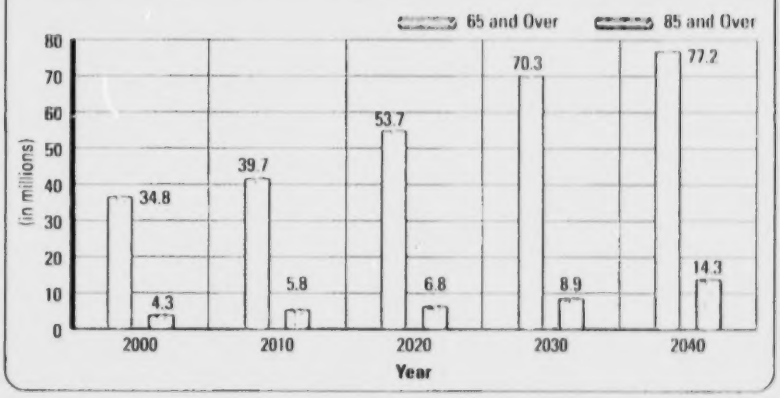
A LOOMING CRISIS IN CARE

Both the current and developing shortages could not come at a worse time. With an aging population and the "baby boomers" entering years of higher incidence of disease, the demand for health care services and the need for people to provide care are increasing significantly:[11]

Percent of Population in:			
Age Group	**1950**	**1998**	**2030**
9 and under	20%	15%	13%
10-19	14	14	14
20-29	16	13	13
30-39	15	16	13
40-49	13	15	12
50-59	10	10	10
60-69	7	7	11
70-79	4	6	9
80 and over	1	3	5

Older Americans use more health services per capita than the general population, and their numbers will continue to rise dramatically:[12]

Census Bureau Estimate of Population

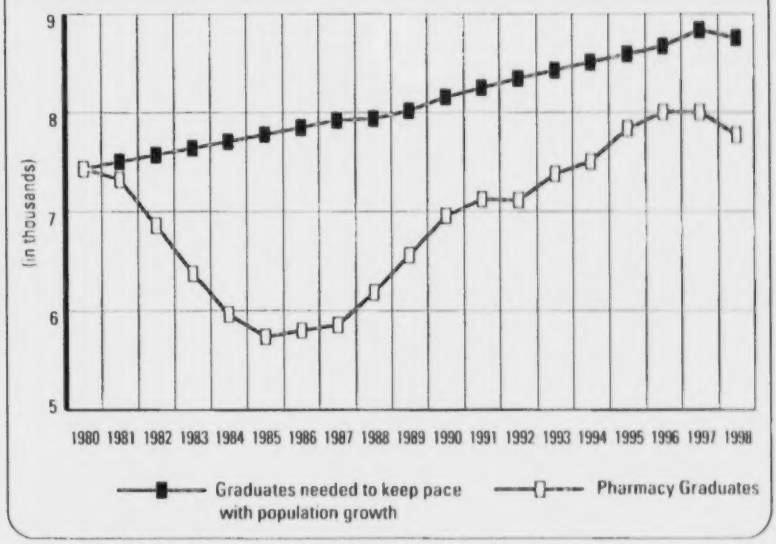


In fact, the Bureau of Health Professions projects that the number of health care jobs will need to grow from 10.9 million in 2000 to over 14 million in 2010 in order to meet increased demand. The rate of growth of new jobs in health care occupations is projected to 28.8 percent, more than twice the rate of employment growth projected for non-health occupations. Or, from another perspective, health occupations are forecasted to be 15 of the 30 fastest growing occupations in America. This growth in demand translates to the need for more than 5.3 million health professions workers to fill the job openings created by departures and new positions:[13]

Number of New Health Workers Needed by 2010

Source: Bureau of Labor Statistics, Occupational Employment Projections to 2010 Monthly Labor Review November 2001

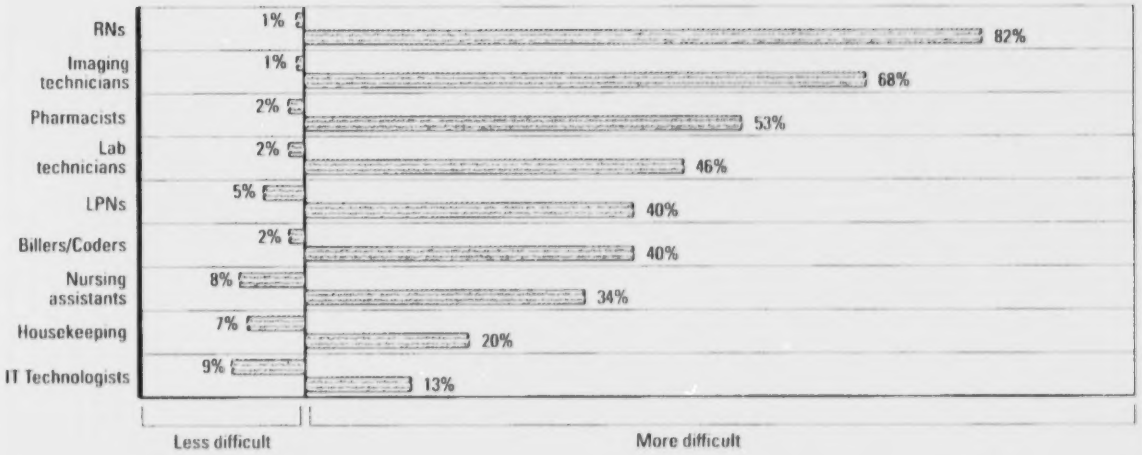
Pharmacy Graduates Versus Number of Graduates Needed to Keep Pace with Population Growth, 1980-1999



Yet, the supply is already not keeping up with the growing demand. While enrollments in educational programs have recently increased somewhat in some markets, overall enrollment in educational programs for health professions, whether hospital-based or in colleges and universities, has declined significantly. There are simply not enough graduates to fill existing or anticipated vacancies.

For example, 13 percent of all hospital pharmacy positions are reported as vacant.[14] Yet, the number of pharmacy graduates has not kept up with demand resulting from population growth for more than 20 years.[15]

Percentage of Hospitals Reporting More or Less Difficulty Recruiting, 1999-2001



And the problem does not relate to one type of worker; hospitals are having significantly more difficulty finding people to work in all types of hospital positions, as the chart above shows:[16]

The challenge is clear: the health care workforce is shrinking in relation to the growing demand for care. And even if enrollment in education programs for health professionals and support personnel increases, the hospital workforce shortage will not diminish if new graduates continue to rapidly leave the hospital setting. Unless these very clear trends are reversed, our nation will face a major health care crisis. Action is needed now!

The growing delays in hospital emergency room care are often caused by a shortage of personnel more than space or beds and are a likely precursor of the health care system's future if nothing is done.

1 The term "hospital" is used throughout the report to simplify the presentation. The Commission uses this term in its broadest sense of the range of inpatient, outpatient, diagnostic, primary, acute, and long-term care services provided through a facility(ies) or a health system.

2 Health Forum LLC, Hospital Statistics 2002. Chicago: Health Forum, 2002, Table 2.

3 For example: nurses, pharmacists, therapists, and some physicians.

4 For example: administration, medical records, housekeeping, and food service.

5 HSM Member Leadership Monitor. Telephone interviews conducted with hospital CEOs by an independent research firm and paid for by the American Hospital Association, July – October 2001.

6 HSM Member Leadership Monitor. Telephone interviews conducted with hospital CEOs by an independent research firm and paid for by the American Hospital Association, July – October 2001.

7 First Consulting Group, The Healthcare Workforce Shortage and Its Implications for America's Hospitals. Fall 2001.

8 U.S. Department of Labor, Working in the 21st Century. June 2001.

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11 National Academy on an Aging Society. Demography Is Not Destiny. January 1999, p. 64.

12 Population Projections Program, Population Division, U.S. Census Bureau, Washington, DC.

13 The New York Center for Health Workforce Studies, Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Occupational Projections, 2000-2010. January 2002.

14 First Consulting Group, The Healthcare Workforce Shortage and Its Implications for America's Hospitals. Fall 2001.

15 Health Resources and Services Administration, The Pharmacist Workforce. Washington, DC: Department of Health and Human Services, December 2000, p. 45.

16 First Consulting Group, The Healthcare Workforce Shortage and Its Implications for America's Hospitals. Fall 2001.

16

Foster Meaningful Work

Hospital work is special. People enter health careers to make a difference in the lives of others. But hospital work is also demanding, hard, and exacting, requiring skill, focus, and attention to detail. As the demands on each caregiver and support worker have increased, the work has become less meaningful and more tedious. This loss of meaning is one of the important underlying reasons hospitals are having difficulty attracting and keeping sufficient workers.

Today, many workers see hospitals as traditional, bureaucratic, and driven by rules and regulations rather than caring. The pace is often hectic, stressful, and exhausting—and not satisfying. They see jobs separated into professional and occupational "silos" that don't coordinate the work in the best interests of the patient.

The nature of hospital work has changed during the past 20 years. New science and technology have added to our capabilities, but have also increased caregiver responsibilities. Expanded outpatient programs and shorter lengths of stay have resulted in the average inpatient being more acutely ill and requiring more intensive service. There are few, if any long-stay, low-intensity patients. At the same time, regulations and documentation requirements force caregivers and support staff to spend more time with paperwork and less time with patients or in activities to support patient service. Many hospitals have been unsuccessful in using information technologies to reduce the regulatory burden, while financial constraints have often placed an emphasis on productivity that minimizes the value of time for personal interaction.

In order to return to more meaningful and rewarding hospital work, job responsibilities, processes and procedures must be re-designed. But because efforts in the 1980s and 1990s to "re-design" work left bad memories of "right-sizing" and "re-engineering," (code words for layoffs), workers are suspicious of work re-design.

What is needed is a new approach to hospital work. Workers and managers must come together from all levels and from all departments of the organization to design fresh approaches to today's job requirements. Retention and recruitment efforts will not succeed in the long-term unless workers have responsibilities that result in meaningful work.

The Commission firmly believes that the work designs of the past satisfy neither patients nor workers. New designs are needed that simultaneously meet the needs of patients, workers, and the hospital as an organization.

The Challenges

Challenge 1

Hospital work must be designed to meet patient, worker, and organizational needs and ensure that the work of caregivers and support staff is meaningful.

Challenge 2

The current workload, including faster pace and fragmentation, may result in harried, dissatisfied caregivers with less time at the bedside.

Challenge 3

It is a challenge for workers to keep up-to-date with the rapid and constant changes in medicine.

Challenge 4

Hospitals must improve their expertise in work design and work processes, and perhaps can learn from other industries.

Challenge 1

Hospital work must be designed to meet patient, worker, and organizational needs and ensure that the work of caregivers and support staff is meaningful.

STRATEGIC RECOMMENDATION

Make the design of work an ongoing priority and core competency of the organization.

TACTICAL RECOMMENDATION

Empower teams of the hospital's staff, including nurses and physicians, to develop new work models.

Example: Due to tremendous growth at Desert Samaritan Medical Center's Emergency Department in Mesa, AZ, the current leadership structure was misaligned with departmental and clinical needs resulting in discontinuity and staff management problems. Utilizing significant input from the nursing, support, and physician staff, the department developed a new ER leadership model in early 2001 centered around the establishment of one Senior Clinical Manager and eight Clinical Managers with well-defined accountabilities. The Clinical Managers are in the patient care setting of the ER 24/7 doing real time problem resolution with a focus on staff competencies and retention, service, and clinical excellence. The ER shared governance model and culture enabled staff and physician involvement in the selection of the new leadership team. The result has been significant increases in staff and patient satisfaction, a 70 percent decrease in patients who leave without treatment, and all nursing positions filled. Contact Ingrid Bachtel, ER Clinical Administrator, at ingrid.batchel@bannerhealth.com or (480) 835-3706 or Eric Heckerson, Sr. Clinical Manager at eric.heckerson@bannerhealth.com or (480) 835-3708.

TACTICAL RECOMMENDATION

Provide the resources and support services employees and medical staff need to efficiently and effectively participate in work design projects.

Example: Designed by a clinical improvement team, an "Attending RN" care model was implemented at Via Christi Regional Medical Center, Wichita, KS. Its purpose was to make a single "entity" accountable for nursing care issues, including clinical and financial outcomes and patient and family satisfaction. Attending RNs staff nursing clinical practice groups that, like physician groups, assume responsibility for evening and weekend coverage via a designated call schedule. An advance practice nurse serves as

the manager for all practice groups. Each practice group has a rotating chairperson who facilitates group decisions related to practice issues. Attending RNs round with physicians and manage the clinical needs of patients through coordination of an outcomes-driven team effort. The model allows the bedside nurse to focus on bedside care, and the nurse manager to focus on operational issues related to recruitment, retention, and budget. Contact Vice President of Patient Operations Sharon Gonzales at (316) 268-8077.

Example: North Mississippi Medical Center (NMMC) in Tupelo, MS, has developed a new model for patient care delivery that, when complete, will have RNs at the bedside managing their patients' plan of care. Current patient care delivery changes include change of shift rounds for nursing staff; added RNs to each shift; nurse-patient sessions each shift to discuss patient care goals; and integrated and interdisciplinary patient medical records. To maximize the time caregivers can spend with patients, equipment is delivered to the patient's floor, while other equipment, such as suction regulators, were purchased for each room. NMMC constantly assesses work design and work environment improvements during staff nurse focus groups. Results so far indicate improved clinical outcomes, as well as improved patient and staff satisfaction. For more information, contact Patti McCue, Vice President for Nursing Service, at pmccue@nmhs.net or (662) 377-3425.

TACTICAL RECOMMENDATION

Determine how recent operational innovations might facilitate new work patterns and improve quality, satisfaction, and productivity.

Example: Evaluate work models that use physician hospitalists or nurse practitioner case managers as the patients' inpatient caregivers, with physicians serving as consultants.

Example: Test "in touch" communications (headsets and wireless devices) in place of patient call buttons and telephones.

STRATEGIC RECOMMENDATION

Develop work designs that balance increased staff satisfaction, safety, and productivity, improved clinical outcomes, enhanced patient satisfaction, and hospital financial viability.

TACTICAL RECOMMENDATION

Involve staff in establishing clearly stated objectives and outcome measures for new work models.

TACTICAL RECOMMENDATION

Implement and reward collaborative and multidisciplinary approaches to accomplishing work.

Example: The Veterans Health Administration (VA) has adopted a new care model based on organizing delivery and coordination of care within small groups of clinicians called "teams." Teams are multidisciplinary teams that provide a coordinated continuum of care to a defined population and are held clinically (and sometimes fiscally) accountable for the health outcomes and the health status of the population served. A team is in essence a group practice of health providers, including physicians, advanced practice nurses, physician assistants, pharmacists, and other allied health professionals. Contact Mark Stanton at mark.stanton@hq.med.va.gov or (202) 273-8560.

Insight: "Collaboration is defined as a 'joint communicating and decision-making process with the expressed goal of satisfying the needs of the patient while respecting the unique qualities and abilities of each professional.' Embedded within successful collaboration are trust, knowledge, shared responsibility, mutual respect, good communication, cooperation, coordination, and optimism."[1]

TACTICAL RECOMMENDATION

Build new work models based on workers' competencies, education, and experience.

Example: Inova Health System, Fairfax, VA, involved hundreds of staff at all levels in the organization to design, plan, determine readiness, and implement a new patient care delivery model called Outcomes Driven Care. It features a quality/case management service that supports collaborative teams' ability to provide case management at the point of service. Data and outcomes information are made available at the point of service so practitioners can more effectively make patient care decisions that affect patient outcomes. The care team members are moving from a task focus to a knowledge base and development of continuous improvement based on data that guides practice. A Discharge Arrangement Center takes the clerical work of discharge planning away from the bedside practitioners. The model has met its goals of improving the patient experience, changing the culture to one of partnership, accountability, commitment to learning and service, improving system integration, and driving costs from the organization. Contact EVP/COO Jolene Tornabeni at jolene.tornabeni@inova.com or (703) 289-2023.

Example: Mississippi Baptist Medical Center in Jackson, MS, is using an innovative approach to assigning patients and float staff to clinical units based on patient needs and staff

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expertise. The concept involves a multidisciplinary staffing team that meets daily to assign patients and clinical float staff to units. Outcomes have shown increased employee morale, lower turnover, higher patient satisfaction, and improvement in wait times for patients in the emergency room, surgery, and admissions. This concept won the MHA - Organization of Nurse Executive Innovation Award for 2001. Contact Debbie Logan, Nursing Director, at dlogan@-mbmc.org or (601) 968-1020.

TACTICAL RECOMMENDATION

Recognize and communicate the differences between generations of workers so that work teams understand and respect their differing perspectives.

Insight: "Companies will have to become more flexible in how they recruit, how they structure jobs, what scheduling options and benefits they offer, how they train, how they manage, how they appraise managers' performance, what behavioral traits are tolerable or intolerable in both older and younger employees, and how they manage the career paths and retirement of their employees."[2]

Insight: Generations differ in the way they see the world.[3]

The Way Generations See the World

	Veterans (Born 1922-1943)	**Boomers** (Born 1943-1960)	**Generation X** (Born 1960-1980)	**Generation Y** (Born 1980-2000)
Outlook	Practical	Optimistic	Skeptical	Hopeful
Work Ethic	Dedicated	Driven	Balanced	Determined
View of Authority	Respectful	Love/hate	Unimpressed	Polite
Leadership by	Hierarchy	Consensus	Competence	Pulling together
Relationships	Personal sacrifice	Personal gratification	Reluctant to commit	Inclusive
Turnoffs	Vulgarity	Political incorrectness	Cliché, hype	Promiscuity

TACTICAL RECOMMENDATION

Embrace the characteristics of the Magnet Hospital program and incorporate them in work innovations.

Sidebar: Characteristics of Magnet Hospitals listed on pages 18-19.

Insight: Outcomes at Magnet Hospitals: Linda Aiken, PhD, RN, Director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania, has studied the Magnet-designated hospitals. She reports that, compared to a cohort of 195 comparable non-magnet hospitals, at the Magnet institutions:[4]

- Patient mortality rates were 4.6 percent lower.
- AIDS patients were 60 percent more likely to depart the hospital alive.
- Nurses suffered far fewer needlestick injuries.
- Patient satisfaction scores were significantly higher.
- Nurses enjoyed significantly greater immunity to job burnout.
- Nurses believed the care that patients received was better than at non-Magnet facilities.

TACTICAL RECOMMENDATION

Explore clinical care models that emphasize continuity of care and improved quality outcomes.

Insight: Define the role family members may have in a patient's hospital care.

Insight: Eliminate work designs that include frequent "handoffs" among staff. They add little value, are not rewarding, and impose administrative hassles on employees.

TACTICAL RECOMMENDATION

Modify work design and environments to retain older workers.

Example: One way to retain the skills and experience of older workers is by utilizing them to mentor younger workers. Mentors should be distinguished from other employees and recognized for this special contribution through financial or other incentives, or a recognition event such as a recognition luncheon.

Insight: People's physical capabilities may change over time. Modifying work design and environments will enhance worker safety.

Forces of Magnetism

(The descriptors reflect some of the practices attributed to that particular organizational characteristic.)

Quality of nursing leadership

- Leaders are perceived as knowledgeable, strong risk-takers who follow a meaningful philosophy that is made explicit in the day-to-day operations of the department. They convey a strong sense of advocacy, providing staff with an overall positive sense of support.
- The nursing director and managers are pivotal to the success of the organization.
- The nursing director is critical to the development of a positive nursing situation.

Organizational structure

- The director of nursing is at the executive level of the organization, reporting directly to the chief executive officer.
- Decentralized departmental structures allow for a sense of control over the immediate work environment and strong nursing involvement in the committee structure across departments.
- With regard to staffing, quality of the staff is as important as the quantity.

Management style

- Participative management style is characterized by involvement of staff at all levels.
- Participation is sought, encouraged, and valued; nursing administration is both visible and accessible.

ORGANIZATIONAL ELEMENTS OF MAGNET HOSPITALS

- Communication is a two-way process with active listening, direct staff input, and ongoing information about what is happening within nursing and the broader organization.

Personnel policies and program

- Salaries and benefits are competitive.
- Shift rotation is minimized, if not eliminated, and creative and flexible staffing arrangements are tailored to meet staff needs.
- Significant administrative and clinical promotion opportunities reward expertise with both title and salary changes.

Professional models of care

- The model of care gives the nurse the responsibility and related authority for patient care.
- Nurses are accountable for their own practice and are coordinators of care.

Quality of care

- The nurses believe themselves to be providing high-quality nursing care to their patients.
- Directors of nursing and nursing management are viewed as responsible for developing an environment where such care can flourish.

Quality assurance

- This is considered a mechanism to improve quality of care.
- Nursing staff involvement in the development of the plan, implementation, and data collection results in improved nursing care.

Consultation and resources

- Knowledgeable experts, particularly Clinical Nurse Specialists, are available.
- The magnet climate is one of peer support, both intra- and inter-professionally, and there is great awareness and appreciation of agency and community interchange or resources.

Level of autonomy

- The nurses are permitted and expected to exercise independent judgment.
- Autonomy is viewed as self-determination in practicing according to professional nursing standards.
- Interdisciplinary decision making is essential.

Community and the hospital

- Nurses support active community outreach.
- Nurses want to view their hospital as a model corporate citizen.

Nurses as teachers

- Nurses place a high value on education and teaching by nurses, not only their own personal and professional growth, but also their roles as teachers.
- Nurses derive much satisfaction from teaching, which is viewed as an energizing activity.
- Teaching is seen as both an expectation in the profession and as an opportunity to practice as a professional.

Image of nursing

- Nurses are professionals.
- Nurses are essential providers of health care.

Collegial nurse-physician relationships

- There is a need for mutual respect for each other's knowledge and competence and a mutual concern for the provision of quality patient care.
- Nurse-physician relationships require constant attention and nurturing.

Orientation, in-service, continuing education, formal education, and career development

- Magnet facilities have a high emphasis on personnel growth and development.
- Staff development starts with orientation and is a strong influence on retention, with the gradual introduction of work viewed as important.
- Access to in-service and continuing education related to the area of practice involved is essential; multiple opportunities exist for clinical advancement that is competency-based with specific requirements.

Challenge 2

The current workload, including faster pace and fragmentation, may result in harried, dissatisfied caregivers with less time at the bedside.

Insight: "Which days have we cut from the hospital experience? Not the days of anxiety but the days of gratification! We have sent home the patient who was approaching the exquisite moment in hospitalization when anxiety about an indeterminate outcome and fear of dire complications shade first into hope and then into certainty of success. Utilization review has gnawed at the days of gratification but left the days of anxiety unscathed! The result is a major source of malaise in our contemporary hospital scene: a reduced sense of gratification together with a persistent or even increased sense of anxiety. In short, the sense of anxiety versus gratification (SAG) index has sharply increased."[5]

Insight: If the average length of stay is four days, 25 percent of patients are discharged every day. But, 25 percent patient turnover feels like 50 percent turnover to employees because 25 percent of the patients depart and are replaced by 25 percent new patients.

STRATEGIC RECOMMENDATION

Monitor and measure the number and mix of qualified staff to ensure there are enough workers for safe, timely care that is satisfying to patients and staff.

TACTICAL RECOMMENDATION

Develop better methodologies for measuring work and scheduling staff that:

- *anticipate demand;*
- *adjust for the learning time essential for new employees;*
- *accommodate the physical limitations of older employees;*
- *acknowledge the short-term loss in productivity that occurs when persons experienced in one clinical specialty are assigned to another area;*[6] *and*
- *recognize the "information burden" as well as the "task burden" imposed by new patients.*

Example: In Missouri, St. John's Mercy Medical Center's nursing leadership and the Sisters of Mercy Health System Corporate Office Operations Consulting and Clinical and Nursing Services Departments engaged in a pilot study to examine metrics used to schedule staff, make staffing decisions, and monitor staff utilization. Midnight census has traditionally been used as the primary measure of work in the inpatient nursing environment. Due to the rapid throughput of patients on many units in today's environment, this

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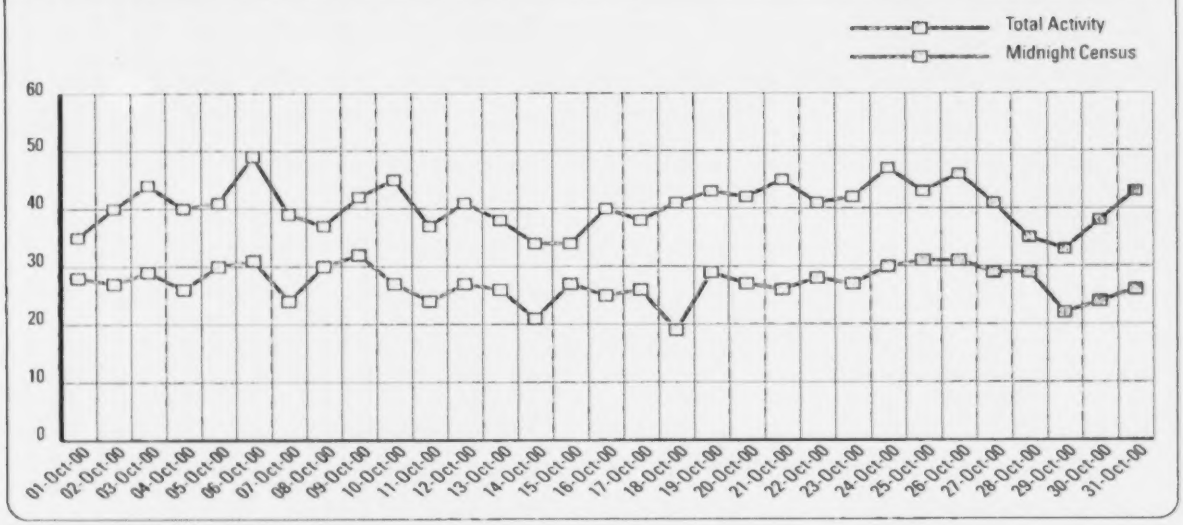
Comparison of Midnight Census to Total Patient Activity



pilot explored how patient activity volume (defined by "total treated" number of patients, i.e., sum of full-day patients, admissions, discharges, transfers, etc.) can be utilized to support staff planning and decision making.

As shown by the graph above, total patient activity volume is significantly higher than the midnight census on the St. John's Telemetry Unit. This data, as well as total patient activity volume by day of the week and hour of the day, revealed patterns and trends. St. John's then made adjustments to the unit's staff schedules, such as creating four-hour shifts for peak admission/discharge hours. The result has been more effective and efficient use of staff worked hours, along with improved staff, physician, and patient satisfaction.

Contact Mary Ellen McDonough, Nurse Manager, Telemetry Unit, St. John's Mercy Medical Center at mcdome@stlo.smhs.com or (314) 569-6374 or Rick Dziewiontkoski, Director, Operations Consulting, Sisters of Mercy Health System, at rdziewiontkoski@corp.mercy.net or (314) 957-0483.

TACTICAL RECOMMENDATION

Ensure that systems for measuring work provide caregivers with time to have relationships with patients, not simply time to perform tasks.

Example: Using staff and patient feedback, New York VA Health Care System, Albany, has developed a team approach to care that is more satisfying to patients and caregivers. Nurses are encouraged to identify problems on their units and take an active role in their resolution. Team members meet at the beginning of each shift to discuss the nursing care for assigned patients and desired outcomes. They then go to each patient room to introduce themselves, a brief visit that tends to calm patients and result in fewer calls during the shift. RNs spend three to five minutes with each assigned patient to discuss proposed outcomes and hear patient/family needs. The nursing plan is communicated to other members of the care team through progress notes and discussions, including a 20-30 minute meeting later in the shift to evaluate progress and revise the plan, if needed. To reduce paperwork and admissions time, only team leaders prepare patient reports and one nurse processes all admissions and transfers. In addition, they were able to decompress two overly crowded units into three smaller units, with an education room on each unit. In preliminary feedback, nurses report feeling like part of a team offering improved continuity of care, with quiet time for staff and patient education, while physicians like the more focused units and improved access to computers. Contact Barbara Brady, Operations Manager, at barbara.brady2@med.va-.gov or (518) 626-6524.

TACTICAL RECOMMENDATION

Monitor the growing body of research that examines the relationship between 12-hour work periods and worker performance and satisfaction and if how round-the-clock work jeopardizes patient and worker safety.

Example: Provide support for employees working high-risk hours when biorhythms are at low levels by providing longer or more frequent breaks.

STRATEGIC RECOMMENDATION

Increase the time caregivers can spend in the actual care of patients.

TACTICAL RECOMMENDATION

Introduce new technologies that reduce paper records and the repetitive entry of information.

Example: The University of Kansas School of Nursing and health care information systems experts from Cerner Corporation have teamed up to provide "live" clinical information systems as part of the university's health professions' curricula for nurses, physicians, and allied health professionals. New graduates from this program expect to work in environments that have eliminated redundant and repetitive paper systems and promote technology-based clinical decision making. Contact Judy Warren, RN, PhD, University of Kansas at jwarren2@KUMC.edu or (913) 588-4286.

Example: Washington ENT Group is a newly established ear, nose, and throat practice in Washington, DC, that is completely paperless. Everything having to do with the patient encounter is electronic, from scheduling to billing and prescriptions. Physicians access patient medical records from a hand-held computer, which has full access to the clinic's computer network. The clinic, which invested $300,000 on computers and software, says the results are seamlessness for the patients, efficiency for clinicians, and faster claims fulfillment. Contact CEO Barth W. Doroshuk at bdoroshuk@washingtonent.com or (202) 785-5595.

Insight: Include fail-safe backups in the automated systems to eliminate the desire to create inefficient and time-consuming duplicate manual backup systems.

TACTICAL RECOMMENDATION

Deploy automated workflow systems in departments such as laboratory, radiology, pharmacy, and emergency services that allow for continuous tracking of both procedures and patients.

Example: The Sisters of Mercy Health System – Arkansas Region has utilized automation in several ancillary service departments to transform and standardize behavior in particular at their St. Edward's Mercy Medical Center facility in Ft. Smith, AR, resulting in operational effectiveness that aids in addressing multiple workforce and job satisfaction issues. Contact: Larry Blevins at (501) 478-4730.

TACTICAL RECOMMENDATION

Recognize acute care nursing outside intensive care specialty units as a valued clinical role rather than as "undifferentiated" general service.

Insight: New staff assigned to general medical-surgical units are often not provided with the same orientation, supervision, and recognition as new staff in ICU specialty units.

TACTICAL RECOMMENDATION

Moderate the traditional morning admissions peak.

Example: Test alternative admission patterns, such as admitting surgery/fasting patients in the morning and elective/diagnostic patients in the afternoon to moderate the traditional morning peaks.

TACTICAL RECOMMENDATION

Cross-train staff to work in new units so that an existing, experienced, internal float pool of talent is available.

Example: Faced with large debt and possible closure of the hospital, leadership at 17-bed East Adams Rural Hospital in Ritzville, WA, devised an inventive cross-training program. Fourteen staff members who do other jobs have been trained and certified as nursing assistants. Seven other staff members have been cross-trained as emergency medical technicians. As a result, the hospital no longer hires nurses from temporary staffing agencies. Contact Nursing Director Amy Sawyer at amylsawyer@hotmail.com or (509) 659-1200.

Insight: Using inexperienced agency staff on a unit increases the burden on regular staff who must add to their workload the supervision of inexperienced agency staff.

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Challenge 3

Medicine is a field of rapid and constant change: it is an ongoing challenge for workers to keep up-to-date as new clinical procedures are developed, new drugs are introduced, and innovative work processes are designed.

STRATEGIC RECOMMENDATION

Create the capacity to keep all staff up-to-date.

TACTICAL RECOMMENDATION

Build mechanisms, including education, coping skills, and innovative necessary technologies, for workers to have new, updated competencies, including evidence-based practice information for clinicians.

TACTICAL RECOMMENDATION

Provide training and skills development opportunities as new technologies are introduced.

Insight: Make sure your organization's educational programs include training for new technologies.

Insight: The increasing use of more sophisticated equipment and systems throughout the hospital is facilitated if the science and math competencies of caregivers and support staff are increased.

TACTICAL RECOMMENDATION

Deploy an automated information system that helps guide clinicians' decisions at the point of care.

Example: Good Samaritan Regional Medical Center in Phoenix, AZ, developed 37 automated medication alerts/rules to assist pharmacists and other caregivers in the avoidance of potential adverse drug events. During a six-month study, these alerts identified 596 opportunities to prevent patient injury secondary to adverse drug events resulting in potential annual cost savings of $3 million. Contact Lee Lemelson, RPh, at lee.lemelson@bannerhealth.com or (602) 495-4349.

Challenge 4

Hospitals must improve their expertise in work design and work processes, and perhaps can learn from other industries.

STRATEGIC RECOMMENDATION

Establish partnerships with industries outside of health care to learn from their expertise in designing work and work processes.

Example: Northwestern Memorial Hospital (NMH) and GE Medical entered into a strategic partnership arrangement in August 2000 in support of NMH's Best People and Best Patient Experience initiatives. Application of the GE Leadership Methods in Healthcare was implemented first focusing on two primary areas: CT Scan and the Emergency Department. Since partnering, NMH has been able to accommodate a higher volume of patients while decreasing backlog and minimizing patient wait time in its CT area. Revising its service model process, several control mechanisms were established to work through capacity restraints in ED, in addition to decreasing wait time and improving patient satisfaction. NMH has been pleased with the results of this strategic relationship. Contact: Larry Goldberg, Vice President, Operations, at lgoldber@nmh.org or (312) 926-4787.

Example: The airline industry has been very successful in reducing errors and improving safety through the implementation of crew resource management training. This approach incorporates strategies for improved team communication and coordination. Sentara Healthcare in Norfolk, VA, is implementing two programs using the techniques and tools of crew resource management in the Emergency Department and in Labor and Delivery. The approach includes active involvement of all staff including physicians and nurses in the work areas. Contact: Manager of Performance Improvement Shannon M. Sayles, RN, at smsayles@sentara.com or (757) 668-3197.

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1 M. K. Wakefield and E. T. O'Grady, "Putting Patients First," in Collaborative Education to Ensure Patient Safety. Washington, DC: Health Resources and Services Administration, 2000.

2 D. Piktialis, "Workforce Planning for an Aging Society," in Working Through Demographic Change. Boulder, Colorado: Human Resource Services, Inc., 2001, p. 18.

3 R. Zemke, C. Raines, and B. Filipczak, Generations at Work. New York City: American Management Association, 2000, p. 155.

4 L. K. Aiken, et al., "The Magnet Nursing Services Recognition Program," American Journal of Nursing, March 2000, pp. 26-35.

5 M. Rabkin, "Occasional Notes: The SAG Index," New England Journal of Medicine, November 18, 1982, pp. 1350-1351.

6 P. Benner, From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Menlo Park, California: Addison-Wesley Publishing Company, 1984.

CHAPTER 2

Improve the Workplace Partnership

In order to solve the workforce crisis, individual hospitals need to recruit new employees into the organization. But the overall situation will not improve if employees leave organizations as fast as new workers are hired. Retention is just as important as recruitment.

Employees leave organizations for many reasons, but most often because their individual needs are not being met. Their needs may be as fundamental as compensation and benefits, or more complex such as recognition, opportunities for professional growth, career advancement, the quality of supervision, or the ability to have a schedule that corresponds to personal needs. If each employee's contribution is not appreciated and recognized, it is unlikely he or she will be a long-term worker.

Today, working in organizations must be a partnership between the employees and the employer. While the employing organization has legitimate needs, including fulfilling its mission and maintaining economic viability, equally important is having a workforce committed to these same goals. That commitment will only occur if the organization follows contemporary human resource practices that include active dialogue with employees, an understanding of their needs and desires, and a diligent effort to respond to those needs.

Certainly the employee-employer relationship has the potential for tension because maximizing employee interests may not maximize the organization's interests. However, strong employee-employer partnerships can be built where there is a balancing of needs and a desire to create an environment that benefits both. The Commission recognizes that in some hospitals groups of workers are members of unions or other forms of employee representation. Where unions are present, the partnership between employees and employers expands to include the employees' legitimate representative.

Unfortunately, too many in today's hospital workforce are expressing genuine dissatisfaction about working in hospitals. Aon Consulting's Loyalty Institute and the American Society for Healthcare Human Resources Administration (ASHHRA) have studied employees at work in health care and employees in the general economy. The Aon work uses a Performance Pyramid™ to understand how organizational attributes influence employee commitment (see sidebar: Aon's Performance Pyramid™). Their findings show that many hospitals fail to meet the expectations of their employees far more frequently than employers in other industries do.[1]

The Challenges

Challenge 1

Many hospital workers do not feel valued.

Challenge 2

Hospitals must have qualified and capable supervisors and managers in order to have satisfied and long-term employees.

Challenge 3

Hospitals need to retain their current and new workers.

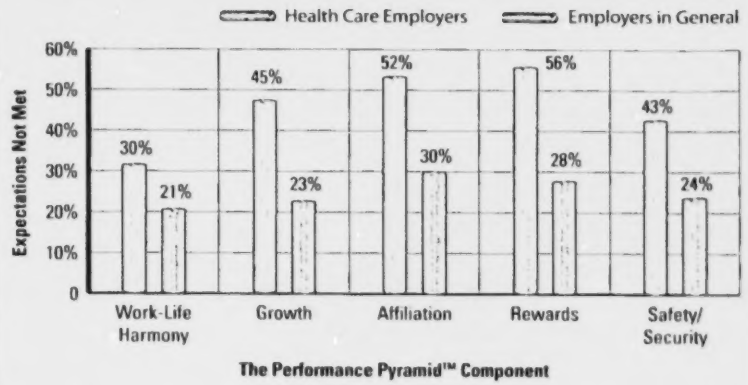
Challenge 4

Hospitals must develop rewards for workers that reflect their high value to the organization.

Challenge 5

Hospitals need to improve human resources management and processes.

Percentage of Employees Whose Expectations Are Not Being Met



Hospital leaders need to determine the unique opinions of their workers and design specific human resource strategies to respond. As part of the response, hospital leaders need to recognize that there are significant differences between the generations, and that an increasingly diverse workforce has legitimate cultural differences that need accommodation.

An effective employer-employee partnership can occur if hospital workers can provide reasonable input into the future of their organization and have the ability to influence its direction. Strong, contemporary, and participatory supervision and management are essential to success.

AON'S PERFORMANCE PYRAMID™

Aon Consulting's worldwide investigation of worker commitment focuses on the controllable factors and conditions that organizations can use to increase employee commitment.

Meta-analyses of the responses of more than 60,000 people led Aon to develop a pyramid of commitment needs in the modern employee/employer relationship. The Performance Pyramid™ asserts that needs at the foundation (beginning at Safety/Security) must be met before attending to those higher levels (ending at Work/Life Harmony).

The five levels of workforce needs, as shown in the Performance Pyramid™, are:

Safety/Security. Along with a physical sense of well being, there must be a psychological belief that the environment is safe from fear, intimidation, or interpersonal treatment that is threatening. Though change is accepted as a constant in today's workplace, a belief that change will radically disrupt the employment relationship will accentuate the basic need for security.

Rewards. Compensation and benefits have been shown for years to be the major reason people take jobs. It is also commonly accepted that their motivation and commitment power increasingly diminishes once the candidate becomes an employee. Because of this, it has been stated that these items have come to be seen as "entitlements," not motivators. The Performance Pyramid™, however, places rewards as a fundamental foundation that must be in place before higher level needs become commitment drivers.

Affiliation. Belonging that includes being "in the know" and "part of the team" is key at this level. Being part of something larger than oneself has been understood as part of human psychology for decades and translates into being more than just a "worker" when on the job. Successful cultures strengthen this natural need to belong and thus encourage the individual to be a strong contributor. Leaders who communicate a strong sense of mission, vision, and strategy enable the need for affiliation to be met.

Growth. Employees want opportunities to change, learn, and have new experiences on the job. The @Work studies have shown that this level is not only about individual growth, but a desire for the organization to grow and change in its work processes, products, and its ability to satisfy customers. Employees also want their work team to improve in efficiency, effectiveness, quality, and productivity. The overall need at this level can be characterized as achievement, whether that success is seen as taking place within the individual, the work group, or the overall organization.

Work/Life Harmony. Similar to the idea of individual self-actualization, employees want to reach their potential both on the job and in other facets of life.

Challenge 1

Many hospital workers do not feel valued and discourage others from entering health care.

STRATEGIC RECOMMENDATION

Hospital and health system leaders, including governing boards, executives, managers, and physicians – must create a culture in which all workers feel valued.

TACTICAL RECOMMENDATION

Increase the ability of employees to be heard by decision makers at all levels in the organization.

Example: The nursing shared governance model of St. Mary's Hospital Medical Center in Madison, WI, requires managers to share decision making, information, and accountability with their staffs and to become facilitators. The hospital shares as much information with staff as possible to help them with their role in decision making, from data on financial trends to strategic and legislative initiatives. Staff nurses have a voice in the hospital's strategic planning process and in responding to areas of dissatisfaction with their work environment. The hospital's social work, pharmacy, and rehabilitation staffs have also adopted this model. Contact Vice President for Patient Services Joan Ellis Beglinger at Joan_Beglinger@ssmhc.com or (608) 258-6735.

Example: Suburban General Hospital in Pittsburgh is creating a "shared leadership" culture aimed at fostering a positive environment for staff and employees. Two staff committees – a clinical council and a work-life council – focus on ways to promote high-quality, patient-centered clinical practice and bolster staff morale. The hospital's human resources and operations executives serve as liaisons to the employee councils, helping to remove barriers if necessary. In the past year, employee turnover has fallen from 25 percent to 15 percent. Contact President/CEO Frank DeLisi at (412) 734-6000.

Example: Baptist Hospital in Pensacola, FL, has seen its turnover rates drop significantly since implementing internal communications initiatives in 1996. Employee forums are conducted quarterly by the administrator with staff on all three shifts three or four times a year. These meetings provide financial, patient satisfaction, and quality updates, as well as offering employees a chance to give feedback directly to the administrator. It is part of a "no secrets" culture. Employees are also involved in peer interviewing to help with quality hiring decisions. Contact Jan Pressley at jpressley@bhcpns.org or (850) 469-2335.

Insight: In prior years, many health care workers trained in hospital-based programs, and students may have been socialized informally to expect limited involvement in institutional decisions. As training programs have moved to community colleges and universities, students are socialized to expect involvement in institutional decisions.

Insight: Generations X and Y have high expectations for participation. Failure to meet this expectation is a major negative for any organization.

Insight: "The data [on registered nurses in New Jersey, information technology workers in Washington State, and engineers and technicians at Boeing] paint a picture of a group of individuals who are happy with and highly committed to their professions but often dissatisfied with their working conditions. The opportunity to make a contribution is what they value most in their professional lives, but workday matters, such as salaries and benefits, are what they believe need the most improvement. They often hold negative stereotypes about unions but offer conditional support for these institutions, especially where there are professional frustrations or problems with management. They want to work collaboratively with their managers, but it is only in the most organized professions – teaching and nursing – that a majority feels that a process exists for discussion of both individual and group concerns with management. Whether or not they want a union, they share a desire for the organizations they join to serve their professional needs and interests, including providing them with access to professional training and helping them improve the quality of the services they provide."[2]

TACTICAL RECOMMENDATION

Help employees develop the skills necessary to understand and participate in discussions of organizational issues.

Insight: Not all employees want to participate in discussions of organizational issues, but, for those who do, effective participation requires the employee to have the background and knowledge necessary to participate. It is offensive to workers to exclude them because "they don't understand." It is more beneficial to establish training programs that provide employees with the knowledge necessary to participate in the discussion on an informed basis.

TACTICAL RECOMMENDATION

Routinely measure worker perception of the organization's culture, including its respect for employees.

Insight: Hospitals are using a number of vehicles to increase communications, including surveys of worker views conducted at least annually, face-to-face forums with senior executives, employee e-mail, and town hall meetings. Of particular importance is ensuring that workers assigned to evenings, nights, and weekends have the same opportunity for input as those who work during weekdays.

Challenge 2

Hospitals must have qualified and capable supervisors and managers in order to have satisfied and long-term employees.

STRATEGIC RECOMMENDATION

Measure, improve, and reward the capabilities of front-line managers. They are key to the retention of satisfied, long-term employees.

TACTICAL RECOMMENDATION

Evaluate the core competencies of first-line supervisors and provide education and mentoring to increase skills, along with the time needed to perform supervisory functions.

Example: New Hanover Regional Medical Center in Wilmington, NC, has developed "The Buddy System" to improve morale and help employees accept change. Supervisors throughout the hospital must attend the training and choose a staff member who reports to them and is respected by co-workers to attend with them. In the training, the buddies role play difficult real-work scenarios. This training has strengthened feedback and respect between line leadership and staff, and helped coordinators and buddies learn to deal with poor performers, deliver controversial messages, and handle criticism. Contact Judy O'Neal, VP Public Affairs, at judy.oneal@nhhn.org or (910) 343-7000.

Example: The Fred Hutchinson Cancer Center in Seattle has implemented Management Learning Groups for peer mentoring. Managers with similar levels of authority are formed into groups of 10 that meet once a month to confidentially discuss challenges in managing people, dealing with organizational politics, managing resources, and dealing with complexity. Discussions are strictly confidential and led by experienced facilitators with backgrounds in management. Learning Group members are asked for an initial commitment of six months and then decide biannually whether the group will continue or not. Contact Kim Wells at kwells@fhcrc.org or (206) 667-2789.

Example: DCH Health System, a three-hospital health system in West Alabama, has a Leadership Development Program for managers, supervisors, and directors. The program is presented in three phases, each phase consisting of six, one-day sessions over three months. The phases: (1) Development of Leadership Theory; (2) Building Interpersonal Competencies; and (3) Enhancing Team Building Competencies help managers improve patient and employee satisfaction, efficiently and effectively manage resources, meet the needs of a changing workplace, and develop trust and commitment to maximize team effort. For further information, contact Mike Laus at mlaus@dchsystem.com or (205) 750-5050.

TACTICAL RECOMMENDATION

Develop approaches to assess and hire managers based on the ASHHRA list of key middle management competencies on pages 34-35.

TACTICAL RECOMMENDATION

Provide first-line supervisors with skills development aimed more for the management of those they supervise than the skills needed for senior management.

Example: The University of Texas Medical Branch has created a leadership development series comprised of three components: (1) The Emerging Leader - designed to build on existing strengths and develop communication and team skills; (2) Supervisor Certification program - designed for first-line supervisors to provide them with knowledge and skills to be more productive managing work processes and people; and (3) Manager Certification – designed to focus developing skills in the areas of leadership and coaching, managing teams, life/work balance, and change management. Contact Doug Stark at dgstark@utmb.edu or (409) 772-7900 or Annette DiPiero at amdipier-@utmb.edu or (856) 489-6501.

TACTICAL RECOMMENDATION

Develop a succession plan for every supervisory position.

Insight: Before any position becomes vacant, identify and evaluate the most likely internal candidate(s).

TACTICAL RECOMMENDATION

Design the role of front-line supervisors so that they are on-site and have the time to effectively coach, mentor, reward, assess performance, and hold individuals accountable for results.

KEY MIDDLE MANAGEMENT COMPETENCIES

Advice from the American Society for Healthcare Human Resources Administration

Results Orientation—A leader who is a business driver able to manage for results in key areas such as clinical quality, service excellence, people management, and financial management.

- Accepts personal responsibility for results;
- Consistently delivers on commitments;
- Makes sound, timely decisions;
- Takes a strategic approach to identifying problems and opportunities and setting priorities;
- Aligns strategic operational and tactical objectives;
- Meets and surpasses expectations, goals, and objectives.

Skilled Communicator—A leader who creates an environment of mutual trust and respect and two-way communication.

- Clearly defines expectations;
- Communicates effectively using multiple methodologies;
- Actively listens to others' ideas and concerns and responds in an appropriate manner;
- Facilitates both disagreement and consensus.

Team Builder—A leader who hires, retains, develops, and promotes talented people and builds team spirit.

- Cultivates a positive work environment;
- Gives frequent constructive feedback and coaching;
- Rewards and recognizes employees' performance;
- Values diversity in all of its forms;
- Effectively manages conflict;
- Manages and motivates individuals and teams.

Agent for Change—A leader who challenges traditional practices and actively pursues positive change.

- Optimistic and displays a "can do" attitude;
- Aligns people with the organization's mission, vision, values, and culture;
- Aligns people with the organization's strategic, operational, and tactical objectives;
- Takes calculated risks and encourages others to do so;
- Personally responsible for their own development;
- Adopts new approaches when circumstances demand it.

Commitment to Service—A leader who demonstrates a willingness to serve key constituents, including patients, coworkers, physicians, the community, and the organization.

- Clarifies service requirements and expectations;
- Assumes personal responsibility for meeting service requirements;
- Understands the underlying sources and issues behind customer needs and attempts to address them;
- Identifies emerging needs and proactively acts to address them.

Collaborative Relationships—A leader who is able to work in interdisciplinary teams for the benefit of the organization as a whole.

- Actively works to develop positive group interaction;
- Aware of what others are thinking and feeling;
- Ability to persuade others;
- Ability to be persuaded by others;
- Expresses positive expectations of others' abilities and expected contributions;
- Solicits ideas and opinions from other individuals and units;
- Frequently exchanges information and resources with others throughout the organization;
- Promotes organizational cooperation by sharing resources with other individuals and units;
- Resolves cross-organization conflicts by seeking win-win solutions.

Resource Management—A leader who is able to manage effectively the organization's human, financial, technological, and other key resources.

- Budget planning;
- Analysis of financial statements;
- Productivity and workload management;
- Forecasts labor supply and demand;
- Develops business plans, action plans, and other detailed planning documents.

Analytical Thinking—A leader who is able to organize the parts of a problem or situation by breaking it apart into smaller pieces, making systematic comparisons of different features or aspects and taking a step-by-step approach.

- Breaks problems down into tasks or activities;
- Links together pieces and sorts out tasks in order of importance;
- Breaks down a complex problem into smaller parts;
- Analyzes relationships among several parts of a problem or situation;
- Anticipates obstacles and thinks ahead about next steps;
- Systematically breaks multidimensional problems or processes into component parts.

Personal Integrity—A leader whose actions are consistent with what she/he says, who communicates ideas and feelings openly and directly, and who welcomes openness and honesty from others.

- Ability to make difficult decisions in the face of conflicting demands and interests;
- Is open, honest, and trustworthy;
- Publicly admits having made a mistake;
- Takes action based on values even when significant cost or risk is associated with doing so;
- Challenges others in powerful positions to act on espoused values.

Talent Development—A leader who has a genuine commitment to foster the growth and development of others.

- Provides a balanced and realistic assessment of an individual's strengths and developmental needs;
- Matches an employee's strengths with the needs of a job or task and makes assignments accordingly;
- Provides timely and specific feedback with the intent of improving performance;
- Provides expectations for future performance or specific suggestions for improvement;
- Arranges appropriate and helpful stretch assignments, formal training, or other experiences for the purpose of fostering a person's growth and development;
- Provides needed support to buffer the individual from possible failure;
- Works with employees to build long-term career plans;
- Participates in and fosters discussions aimed at developing talent to meet the long-term needs of the organization;
- Actively develops talent, including subordinating the talent requirements of one's area when doing so is in the larger interest of the organization.

Leadership Effectiveness

- Ability to create a shared mission and vision;
- Ability to establish goals and objectives to achieve the mission and vision;
- Ability to engender support from subordinates, peers, and superiors;
- Ability to facilitate involvement and participation on the part of key stakeholders.

Challenge 3

The workforce shortage will not be solved unless current and new workers are retained in hospitals.

STRATEGIC RECOMMENDATION

Learn what makes workers remain in the organization and become long-term employees.

TACTICAL RECOMMENDATION

Use retention rates, not turnover rates, to understand employee stability.

Example: Clinical nurse managers at Evanston Northwestern Healthcare in Illinois use a tool termed the "Retention Grid" to stratify turnover risk on their units. To assist managers in prioritizing their unit-based retention efforts, each nurse is assessed by their manager using "departure risk" and "impact of staff member departure" criteria. Contact Bill Luehrs, Senior Vice President, Human Resources, at (847) 570-5225 or Mary Lou Powell, RN, Vice President, Patient Services, at (847) 570-2409.

Example: Birchwood Companies' (Plymouth, MN) long-term care organization tracks employee stability (employees retained at the end of the calendar year who were employed at the beginning of the year) along with turnover, reasons for leaving, and longevity of current staff. Contact Human Resources Director Diana Rockstad at drockstad@birchwood-co.com or (763) 745-3322.

Insight: "[Turnover rates] are difficult to interpret. For example, does a 50 percent turnover rate mean that one-half of a company's employees left during the year, one-fourth of the employees turned over twice, or 10 percent of the employees turned over five times?"[3]

TACTICAL RECOMMENDATION

Compute retention rates at both organizational and unit levels to identify high-departure areas and determine the factors contributing to departures.

Example: Kadlec Medical Center in Richland, WA, developed a nursing unit-specific recruitment forecasting methodology based on historical and projected factors. Historic factors include the average age of RNs working on each unit, the 3-year historic turnover rate of voluntary terminations, and current vacancy rates. Other factors such as expansion of service, staffing changes, and medical staff changes are also factored in. From this baseline, the hospital can predict the anticipated needs for staff by unit. This provides a minimum threshold for the number of vacancies that will arise in the next 12 months. Contact: Janet Blake, Kadlec Medical Center, blakej@kadlecmed.org.

Insight: Determine whether current bed assignment practices group "difficult" and "high stress" patients in specific units, thus contributing to low retention rates.

Insight: Determine whether assigning new nurses to medical-surgical units contributes to supervisory burnout due to the extra demands placed on personnel responsible for large numbers of new hires.

Insight: Examine patient units with low retention rates to see whether physician behaviors (e.g., abusive language, sexist remarks, or failure to return pages) are contributing to dissatisfaction.

TACTICAL RECOMMENDATION

Develop programs to assimilate and support employees throughout their career at the organization. Don't orient employees only when they start working at the hospital.

Example: In response to turnover data showing that 38 percent of new employees left within a year, Chicago's Louis A. Weiss Memorial Hospital developed a hospital-wide preceptor program. Each unit selected a preceptor for new employees. The preceptors were trained in a four-hour session. Turnover in the past two years has been reduced to 15 percent. Contact Stephen Modde, VP Human Resources, at smodde@weisshospital.org or (773) 564-7222.

TACTICAL RECOMMENDATION

Measure the direct and indirect costs of employee departures to understand the cost-effectiveness of retention initiatives.

Insight: "Direct turnover costs are fixed, requiring expenditure of time or money for existing employees and their replacements. Participating companies estimated the following direct turnover costs:

- Separation costs, including exit interviews, personnel department costs, and separation pay;
- Replacement costs, including employment advertising, pre-employment testing (including drug testing and background checks), new employee processing, and new employee orientation;
- Training costs, including formal training and on-the-job training.

Opportunity or indirect turnover costs encompass items such as paperwork errors, inventory shrinkage, improper use of equipment, and change-making errors, caused by replacement employees' lack of experience. These costs are difficult to estimate because companies typically do not have procedures to track them."[4]

Insight: Investments in safety and security that increase employees' well-being are a factor in reducing worker turnover.

Insight: In his recent book *Loyalty Rules!: How Today's Leaders Build Lasting Relationships*,[5] Frederick Reichheld studied almost 100 companies in a dozen industries and found " . . .5% swings in retention rates resulting in 25% to 100% swings in earnings – in both directions."[6]

TACTICAL RECOMMENDATION

Establish retention goals and reward managers for achieving them.

Challenge 4

Hospitals must develop a range of rewards for workers that reflect their high value to the organization.

STRATEGIC RECOMMENDATION

Work with employees to develop a comprehensive rewards strategy that broadly reflects the high value of hospital workers to their communities and the hospital.

Insight: In addition to compensation and benefits, the Total Rewards™ concept involves the Work Experience, which includes:[7]

Acknowledgement, Appreciation, and Recognition – such as service, spot, and achievement awards; feedback; and other initiatives that achieve the desired result of fulfillment in employees.

Balance of Work/Life – such as family programs; financial/health counseling programs; convenience services; employee activities; non-traditional work arrangements; and other factors that contribute to a high quality of life.

[Corporate] Culture – such as leadership; diversity; organizational formality; opportunity for innovation; and degree of employee communications.

Development – such as learning opportunities; coaching; mentoring; feedback; opportunities for career advancement; and educational opportunities.

Environment – such as the job (content, variety, context, tools, clear line of sight, attainable objectives); the place (the physical work environment); and the company (products, markets, organizational structure, and success - the opportunity to work for a thriving company).

Insight: Temporary employment firms have attracted caregivers and support staff by offering a different mix of rewards. Study the strategies of temporary firms to identify the features that workers find so attractive and evaluate their use for permanent employees.

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STRATEGIC RECOMMENDATION

Include a competitive edge in compensation in the hospital's comprehensive rewards strategy.

The relationship between compensation in the general economy and in health care is unclear. On the one hand, the Bureau of Labor Statistics states "the average earnings of nonsupervisory workers in health services are slightly higher than the average for all private industry, with hospital workers earning considerably more than the average, and those in nursing homes and personal care facilities and home health services earning considerably less."[8]

What is clear is that hospitals will increasingly be competing for the same employees with industries outside of the traditional health services sector. For example, nurses are attractive staff for insurance and pharmaceutical companies, and pharmacists are in great demand through the retail industry. The disadvantages that hospitals currently have in being able to offer competitive salaries are real, as demonstrated in the data above comparing pharmacist salaries in hospitals to those of pharmacists working elsewhere.[9]

Average Total Income ($) of Pharmacists by Employment Settings: 1992-2000.*

Year	Independent	Chain	Mass Merchandiser	HMO	Hospital	Supermarket
1992	47,524	54,267	—	—	51,482	—
1994	51,415	59,176	—	—	55,258	—
1996	54,110	65,495	64,957	70,197	62,048	61,319
1998	59,657	68,648	69,964	69,870	62,510	67,177
2000	76,820	81,903	84,938	88,822	79,097	80,650

Data from Drug Topics Salary Surveys, 1998-2001

TACTICAL RECOMMENDATION

Ensure that hospital compensation strategies adequately reflect differences in education, experience, and competencies.

TACTICAL RECOMMENDATION

Ensure that compensation strategies for employees remain competitive from entrance salary through mid and late career.

Insight: Compensation strategies should provide appropriate recognition for the value long-term employees who remain in caregiver and support roles.

STRATEGIC RECOMMENDATION

Include flexible benefits in the hospital's comprehensive rewards strategy.

TACTICAL RECOMMENDATION

Recognize that workers have different benefit needs and involve them in developing benefit options that provide employees with a choice of benefits that meet evolving needs throughout their career.

Example: *Working Mother* magazine annually selects a list of the 100 Best Companies for Working Mothers. Benefits on which honorees are judged are childcare flexibility, leave for new parents, work/life balance, and opportunities for women to advance.

Example: Mission St. Joseph's Health is located in Asheville, NC, a resort and retirement area where housing prices are 12 percent above the state's housing index. Knowing that home ownership was out of reach for many employees, the hospital teamed up with Fannie Mae and Asheville's Affordable Housing Coalition to develop a program to make homeownership part of the hospital's benefit package. The program includes homebuyer education as well as assistance in securing financing. Contact Beth Marcus, Fannie Mae Director of Marketing, at h_beth_marcus@fanniemae.com or (202) 752-7888.

STRATEGIC RECOMMENDATION

Include an employee recognition component in the hospital's comprehensive rewards strategy.

Insight: Key Components of a Successful Reward and Recognition Program:[10]

- The recognition and reward program is driven primarily by middle management, including department heads and first-line supervisors.
- Employees are recognized for achieving specific organizational results and/or for demonstrating excellence (e.g., clinical outcomes, customer service, financial performance, etc.).
- The types of rewards provided to employees are relevant to what employees really want and not what management thinks or assumes workers will find rewarding.
- The types of rewards provided to employees are significant and meaningful to them (i.e., not slogans, tee-shirts, or coffee mugs).
- Whenever possible, employees are recognized in front of their peers and coworkers and, where appropriate, their family members.
- Recognition and rewards are available to all employees, including front-line employees, middle managers, and executives in both patient care and non-patient care delivery areas.
- In addition to recognizing results, performance, and excellence, employees are recognized for their length of service to the organization.

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- The recognition and reward program is a line item budgeted on an annual basis as an investment in the organization's most important asset – its people.
- Remember that saying "thank you" is one of the most powerful ways in which employees can be recognized and rewarded.
- Employees should be recognized both for their accomplishments at work as well as accomplishments they have achieved in their personal lives.
- Executives and middle managers should be selected, evaluated, and rewarded at least in part on their ability to reward and recognize their employees.
- Recognition and reward programs need to evolve over time in order to remain effective.
- Middle managers and executives need specific training in how to recognize and reward employees.
- Middle managers and executives need to be provided specific tools and resources by which to recognize and reward employees.
- Executive management team members must serve as role models for middle managers if they expect them to effectively recognize and reward their employees.
- An organization's reward and recognition program should strive for fairness and consistency across departments and managers throughout the organization.

TACTICAL RECOMMENDATION

Recognize, celebrate, and accommodate generational differences in your workforce.

TACTICAL RECOMMENDATION

AHA should lead an initiative with other professional and trade associations and employee representatives to develop guidelines for issues seen as negatives among the workforce, including model policies for "on call" notice, "on call" cancellation, and last-resort unavoidable overtime.

STRATEGIC RECOMMENDATION

Include career development in the hospital's comprehensive rewards strategy.

TACTICAL RECOMMENDATION

Enhance orientation, internship, and transition-to-work programs.

Example: A mentorship program at New Hanover Regional Medical Center in Wilmington, NC, has helped reduce staff attrition markedly. By May 2000, 34 percent of the hires from the nursing schools' class of 1999 had left, but in May 2001, the attrition rate for the class of 2000 was just 8 percent. The mentors, who receive no financial compensation, provide career guidance, advice, and leadership to new nurses. They are not preceptors but serve more as role models, coaches, and advocates for the nurses. Feedback from participants indicates that the mentoring program is key to their decision to remain in the organization. Contact President and CEO Bill Atkinson at bill.atkinson@nhhn.org or (910) 343-7000.

TACTICAL RECOMMENDATION

Help each employee have a career mobility plan that considers his or her interests and goals.

Example: Clarian Health's Career Quest®, provides individualized counseling to help employees explore interests, assess skills, set goals, and progress from "where they are now" to "where they want to be" within the system. Enrollees, referred to as "Questors," choose from four different pathways (progression into a new job, admission into a training program, performance improvement/skill enhancement in their current job, or learning for personal/professional development) and five different tracks (clinical/patient care, business/clerical, support services, facilities, or leadership). Each Questor is linked with a career advisor (a "guide") and undergoes a series of assessments to identify occupational interests and current skill levels. Contact Employee Education and Development Manager Sherry Makely at (317) 962-3282.

Example: Exempla Healthcare, Denver, noticed very high turnover rates for entry-level workers in environmental services, nutrition services, and laundry.

The system believed this was due to lack of career advancement opportunity in entry-level positions brought on by deficits in employee skill sets. In response, the Entry-Level Workforce Development Program was established. It provides on-site skill development classes. Participants also work with a program manager to develop a career plan customized to further their career within Exempla. The program is partially funded by a grant from the Denver Mayor's Office of Workforce Development. Contact Sandy Cavanaugh at (303) 813-5335 or at cavanaughs@ exempla.org.

Example: Fairview, an integrated health care system that includes seven hospitals in Minnesota, opened Workforce Development and Placement Centers in 1995 to assist employees with career development, job coaching, primary job placement, transitional service placement, and educational training programs for future job placement. Two staffed centers are located at their largest hospitals, and outreach services are provided to smaller campuses. Resources available to all employees include vocational counseling, computer resource stations, assessment testing, videos, and library materials. To date, there have been over 15,000 consults and hundreds of job placements. In 2001, there was over $11 million dollars in turnover and industrial indemnity savings. Making these services available to employees has increased employee retention, satisfaction, and engagement. For additional information, contact Laura Beeth, Corporate Director of Workforce Development and Placement, at lbeeth1@fairview.org or (952) 924-7077.

TACTICAL RECOMMENDATION

Offer employees opportunities for career and personal growth.

Example: Henry Ford Health System has created a competency-based career ladder program for clinic service representatives and medical assistants. The program features three levels within the ladder structure that offer both career progression and reward for performance. During its first calendar year in operation, over 30 percent of all employees in the job classifications successfully completed the program. Turnover rates have gone from 23 percent to 8 percent for clinic service representatives, and from 17 percent to 9 percent for medical assistants. Contact Pam Theisen, Senior Consultant, Human Resources, at ptheise1@hfhs.org or (313) 874-6089.

Example: As a strategic lever of its Best People Strategy that focuses on retaining and developing the workforce, Northwestern Memorial Hospital in Chicago created an in-house training and education academy and hired a former senior manager at Motorola University to direct it. The academy is staffed by professional educators, advanced degree nurses, and other allied health professionals. It offers training/education and development options in management, cultural competence, clinical skills, customer service, basic literacy, and required annual regulatory training, in support of operations objectives. Through partnerships, it has created virtual allied health schools and programs in nursing and imaging technology. The Academy also manages an infrastructure for education and training, including classrooms, computer labs, on-line catalogues, and tools. Contact: Justin Lombardo, Director, NM Academy, at jlombard@nmh.org or (312) 926-5425.

TACTICAL RECOMMENDATION

Design personnel evaluation systems to distinguish between employees the hospital wants to keep, employees it wants to advance, and employees whose performance, after appropriate acculturation and training, is inconsistent with hospital standards.

TACTICAL RECOMMENDATION

Hospital associations should work with professional associations and educators to develop career paths that encourage career mobility.

Insight: *Many hospital jobs are perceived as dead-end because the prospective employee has to return to school and begin a new educational program "at square one" because there is no recognition of prior education or experience. Establishing credit for prior training and experience could increase the pool of applicants and retain workers in health care careers.*

TACTICAL RECOMMENDATION

Provide or arrange for basic education skills for employees.

Example: *The University of Chicago Hospitals and Health System developed the UCH Academy to serve the education and training needs of staff that are employed by the health system. The learning opportunities offered by the UCH Academy are directly aligned with the business needs of the organization and provide employees an opportunity to acquire new skills that enable them to advance their careers within the organization. The Academy Model is also offered to other health care organizations. Contact Judy Schueler at jschuele@uchospitals.edu or (773) 702-4380.*

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STRATEGIC RECOMMENDATION

As part of the hospital's comprehensive rewards strategy, develop work assignment systems that provide workers with increased control over their assigned hours.

TACTICAL RECOMMENDATION

Involve workers in developing flexible work schedules that provide them with greater personal time flexibility and the hospital with appropriate continuity of care and staff.

Example: St. Peter's Health Care Services in Albany, NY, established a web site that allows nurses to bid on shifts and wages. The hospital's goal is to attract competitive bids from nurses who work for temporary agencies, doctor's offices, or HMOs and to reduce the time nursing supervisors spend filling shifts. St. Peter's has seen a significant decline in its nursing vacancy since the web site's inception. Visit www.stpetershealthcare.org/careers_and_jobs/ or contact Kathy Brodbeck at kbrodbeck@stpetershealthcare.org or (518) 525-1279.

Example: St. Louis (MO) Children's Hospital now offers most pharmacists the option of working a "7 days on, 7 days off" schedule. That option had previously been limited to the night shift. Managers and pharmacists working in clinical departments such as the ICU are excluded by their responsibilities from participation. But half of the hospital's eligible pharmacists now follow this schedule. Those with families report that it has cut their child-care costs in half. It also has helped to build teamwork and consistency on the shifts. Contact Pharmacy Director Christine Pavlak at christip@bjc.org or (314) 454-6161.

Example: Allina Hospitals & Clinics, Minneapolis, has 24 medical record coders who work from home, thanks to a web-based product. Prior to implementing the system, Allina was relying on expensive outsourced coding agencies. Benefits of the Internet-based solution have been increased worker productivity, increased staff satisfaction and retention, reduced costs, and maximization of staffing. When one hospital experiences coding capacity, for example, home coding staff can be assigned charts from another Allina facility. Since implementing the home coding program, Allina has received resumes from more than 80 experienced coders. Contact Kim Pederson, Vice President, Revenue Cycle, at (612) 775-9742.

TACTICAL RECOMMENDATION

Make sure that evening, night, and weekend personnel have access to the same administrative, educational, mentoring, and family support services available to the day staff.

Insight: The tradition of providing support services on an 8-5 schedule contributes to the perception that other shifts are not equally valued and makes it more difficult to retain staff on these shifts.

Challenge 5

Hospitals have many widely used methods to measure the performance of their financial resources. The same attention should be focused on human resources.

STRATEGIC RECOMMENDATION

Give human resources information the same governance and senior leadership attention and priority as financial information.

TACTICAL RECOMMENDATION

Develop a routine human resources report for the Board of Trustees that is deemed equal in importance to the financial report.

Example: For board members at North Mississippi Health Services, the parent organization of North Mississippi Medical Center in Tupelo, MS, human resource issues have become a regular part of the board meeting agenda. NMHS's vice president of human resources briefs board members on the issues, proposals, and activities affecting the health care system's staff and provides regular reports on vacancy, turnover, and retention. The annual retreat for board members and the system's administrative staff offers an opportunity to discuss and set goals for the coming year. Because of this active involvement, board members have supported NMMC's new model for patient care delivery that incorporates changes suggested by staff. For further information, contact Patti McCue, Vice President for Nursing Service, NMMC, at pmccue@nmhs.net or (662) 377-3425.

TACTICAL RECOMMENDATION

Develop human resources reports that measure the organization's investment in human resources and provide them to executives and managers.

Insight: Human resource reports comparable to financial reports would include: (1) sources and uses of personnel; (2) inventory of personnel capabilities; (3) return on development in personnel skills; (4) age distribution of workers; and (5) true cost of turnover.

Example: Henry Ford Health System, Detroit, develops multi-year strategic human resources plans that are integrated and linked to the broader strategic planning process for the system. Leadership throughout the system is involved in the development of the human resources plans and utilizes them as ongoing performance benchmarks. Contact Senior Vice President and Chief Human Resources Officer Bob Riney at rriney1@hfhs.org or (313) 876-8707.

1 Ann Lovely Institute, *Healthcare @Work*. Ann Arbor, Michigan, 2001.

2 "Preface," in *Finding Their Voices: Professionals and Workforce Representation*. The Albert Shanker Institute, 2001, p. 6.

3 *New Ideas for Retaining Store-Level Employees*. Atlanta: The Coca-Cola Retailing Research Council, 2000, p. 9.

4 *New Ideas for Retaining Store-Level Employees*. Atlanta: The Coca-Cola Retailing Research Council, 2000, p. 30.

5 Harvard University Press, September 2001.

6 Business Week, August 13, 2001, p. 8.

7 *Total Rewards℠: From "Employment" to "Engagement."* Scottsdale, Arizona: WorldatWork, 2000.

8 U.S. Department of Labor, Bureau of Labor Statistics, *Career Guide to Industries*, 2002-2003 Edition.

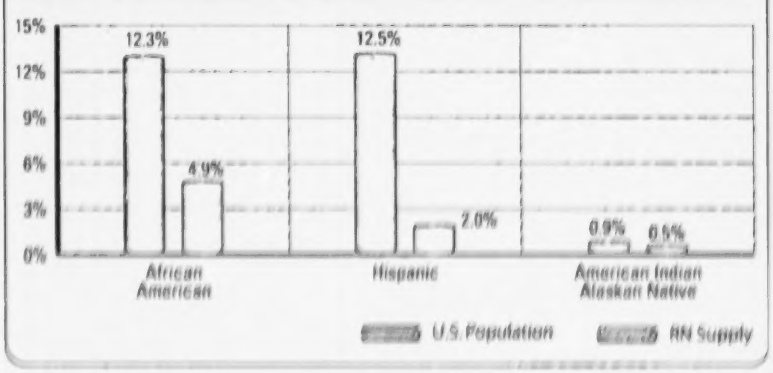
9 U.S. Department of Health and Human Services, Bureau of Health Professions. *The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists*. December 2000.

10 Developed by the American Society for Healthcare Human Resources Administration.

Broaden the Base

Although 10 percent of the U.S. civilian labor force is employed in the health care field, the health care workforce does not mirror the diversity of the general U.S. population - ethnic and racial minorities are severely underrepresented. For example, the table below indicates that registered nurses reflect this lack of diversity:[1]

Racial Composition of U.S. Population and RNs, 2000



In the coming years, as the U.S. workforce grows more slowly, health care will have to compete more vigorously with other industries to attract a shrinking pool of workers. At the same time, the traditional populations that have been the source of most hospital workers will not be sufficient to meet the growing need for health care workers. To date, hospitals have not invested sufficient effort and resources in workforce planning and achieving diversity and will need to work harder to attract those who have not traditionally been a large part of its workforce. This includes not only reaching out to minorities and immigrants who account for an increasing share of the overall workforce labor pool, but also males who have traditionally been underrepresented in many health care occupations, such as nursing. The pursuit of a more broad based, diverse workforce is the only way to ensure that there will be enough people to meet the nation's growing health care needs.

Because role models may be limited for some populations, exposure to health careers must begin early in the educational experience, and students need opportunities within hospitals to make them aware of the many attractive career choices available there.

Improving diversity will not only help solve the workforce crisis, but also enhance the cultural competencies of hospitals, making them more responsive to their communities' health care needs.

The Challenges

Challenge 1

Attracting a more diverse workforce is a hospital business imperative.

Challenge 2

Hospitals need to be attractive employers to all generations of workers.

Challenge 3

Health care is competing with all industries for a smaller pool of potential workers.

Challenge 4

The image of health careers must be improved.

Challenge 1

Hospital employees are disproportionately female and Caucasian. Attracting a more diverse workforce is a hospital business imperative.

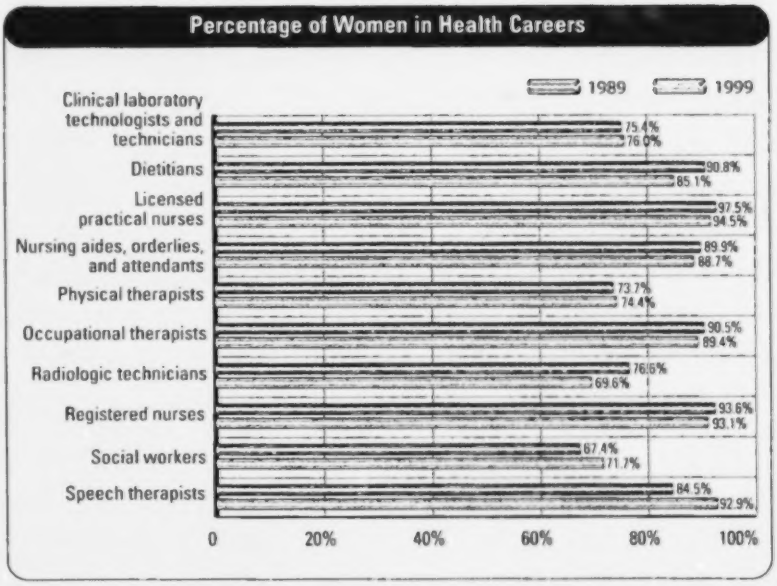
STRATEGIC RECOMMENDATION

Work aggressively to develop a workforce pool that represents the full spectrum of your community's population, including men and women, all racial and ethnic minorities, and immigrants.

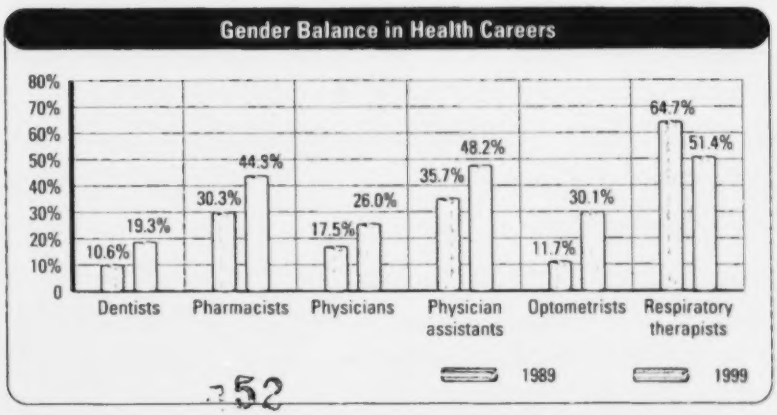
TACTICAL RECOMMENDATION

Work to make health care careers, especially nursing, gender-neutral professions. Health care cannot afford the exclusion of half of its potential workforce due to stereotypes about gender.

Insight: Many health careers have historically been women's work.[2]



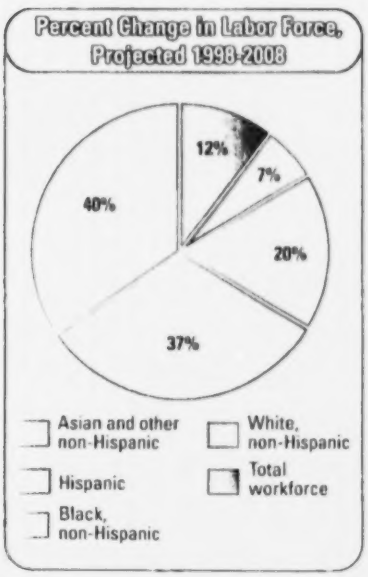
Insight: Several health professions have succeeded in becoming more gender balanced.[3]



TACTICAL RECOMMENDATION

Actively recruit more ethnic and racial minorities into health careers and into your organization.

Insight: The national labor force is becoming more diverse.[4]



Example: SSM Health Care invites prospective and new employees to "Experience the Difference diversity makes" through an eight-minute video that is shown to all new hires and played at job fairs as well as on the system's web site (www.ssmhc.com). SSM's diversity initiative is extensive and pervasive throughout the four-state system and includes hospital-based events supporting an inclusive environment and culture; requires diversity training for all employees; incorporates a diversity mentoring program; sponsors internships and summer development programs for minority students; and presents a Diversity Forum bringing together persons of color, different ethnicities, and disabilities to network and enhance their leadership skills. In addition, SSM Health Care supports the community it serves through its outreach and supplier diversity programs. Contact Yvonne Tisdel, Corporate Vice President-Human Resources and System Diversity, at Yvonne_Tisdel@ssmhc.com or (314) 951-5375.

Insight: Recognize and respect the many facets of a multi-cultural, multi-racial workforce. Celebrate workers' differences instead of attempting to force a single culture of conformity.

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TACTICAL RECOMMENDATION

Reach out to organizations that are a recognized source of ethnic and racial minority employee candidates.

Example: Clarian Health System is partnering with the Indiana Minority Health Coalition to recruit more minority students into health and human services fields. Clarian provides health careers activities for high school students and has collaborated on a federal grant proposal to create a statewide telementoring program and distance learning offerings. Clarian offers Summer Health Careers Camps and Internships for at-risk minority youth in collaboration with Goodwill Industries and the Indianapolis Private Industry Council. Contact Sherry Makely, Manager of Employee Education and Development, at (317) 962-3282.

Example: The Institute for Diversity in Health Management collaborates with educators and health services organizations to expand leadership opportunities to racially/ethnically diverse individuals in health services management. The mission of the Institute is to increase the number of racially/ethnically diverse individuals in health services management and to improve opportunities for professionals already in the health care field. To accomplish its mission, the Institute has designed several initiatives to generate significant long-term results through educational programs, a summer enrichment internship, professional development, and leadership conferences. Contact President/CEO Rupert Evans at revans@aha.org or (800) 233-0996.

Insight: Historically Black and Hispanic colleges and universities (see appendices on pages 86-90 for lists of both) are good sources of talented minorities who might consider the health professions.

Insight: It is important to reach out to minority and nontraditional populations at an early age, when children and their parents are considering future career options.

TACTICAL RECOMMENDATION

Reach out to schools and colleges that serve as a primary point of entry to higher education for immigrant populations.

Insight: More than 50 percent of all first-time higher education students attend community colleges.

Insight: Immigrants and first generation students attend college primarily for purposes of assistance with language and cultural skills, and to find a job.

TACTICAL RECOMMENDATION

Facilitate access to health care training programs for people from nontraditional populations by providing loans, scholarships, and mentoring.

Example: Four hospitals are funding a new nursing program at Florida International University, Miami, to prepare unlicensed foreign-trained physicians to become nurses. Catholic Health East's Mercy Hospital, HCA's Kendall Medical Center, Cedars Medical Center, and Aventura Hospital will pay two-thirds of the student's tuition and underwrite

the cost of faculty and support staff in exchange for a commitment to work for them for three years after graduation. The program can accommodate 40 students annually and currently has a pool of 425 applicants. Contact Mercy's Vice President of Nursing and Patient Services Claudia DiStrito at cdistrito@mercymiami.org or (305) 285-2121.

Example: The Salsbury Scholarship Program at the Arizona Hospital and Healthcare Association supports minority health care students by awarding scholarships to primarily Hispanic, African American, and Native American students seeking careers in health care. The program is in the process of expanding into a scholarship-sponsorship-mentoring program, offering a wide range of support to students, including financial, tutorial, family, and cultural enhancements. Contact Fran Roberts at froberts@azhha.org or (602) 445-4300.

TACTICAL RECOMMENDATION

Help immigrants living in the United States obtain licensure through the appropriate recognition of prior training and experience.

Example: Nurses Helping Nurses is a new initiative organized by the Houston chapter of the National Association of Hispanic Nurses (NAHN) to help foreign-trained nurses overcome licensing and language barriers. Houston NAHN volunteers steer the foreign-trained nurses through the certification credential evaluation process administered by the Commission on Graduates of Foreign Nursing Schools (www.cgfns.org), an independent agency that helps identify foreign-trained nurses eligible for licensure in the United States. Houston-based NAHN is also working with a community college to offer the nurses language training and to prepare for the NCLEX nurse licensing exam. Contact Jacqueline Perry, President of the Houston chapter of NAHN and an ER nurse at Lyndon B. Johnson Hospital, at jperry5414@aol.com or (713) 566-5620.

Insight: The number of immigrants living in the United States has increased rapidly. Prior to the September 11 terrorist attacks, which may lead to a tightening of the borders and less immigration into the United States, it was predicted that immigrants would account for half of all new U.S. workers by 2006. Over the next 30 years, that figure was expected to rise to 60 percent.[5]

TACTICAL RECOMMENDATION

Mentor minority and foreign-trained personnel so they will succeed in health care careers.

Example: Working with the Richmond (VA) Catholic Diocese's Refugee and Immigration Services, Bon Secours St. Mary's Hospital has hired English-speaking support service staff who are refugees from Haiti, Sudan, Afghanistan, and Iran. The workers take tremendous pride in their work and possess an exceptional work ethic that tends to rub off on others. The hospital has offered education and support programs, such as a 14-week "essential skills" class to help employees learn life skills and to encourage retention. Contact: Westin Thiss, Director of Environmental Services, at wes_thiss@bshsi.com or (804) 287-7122.

Challenge 2

The hospital workforce includes multiple generations. Hospitals need to be attractive employers to workers of all age groups.

STRATEGIC RECOMMENDATION

Create specific strategies to attract each generation to your workforce.

TACTICAL RECOMMENDATION

Develop initiatives to become a sought-after employment option for Generations X (born between 1960 and 1980) and Y (born between 1980 and 2000).

TACTICAL RECOMMENDATION

Provide incentives for over-50 employees to shun retirement and continue to work at the organization. This is among the simplest short-term solutions to the current labor shortage.

Insight: "HR directors name flexibility and adaptability to deal with new situations as the most important characteristic for employability, followed by overall skills, high level of commitment, technological expertise, reliability, and motivation. With the exception of technological expertise, these are all areas where older workers are very favorably viewed."[7]

Insight: **Profile of Generation X and Y**[6]

	Generation X (Born 1960-1980)	**Generation Y** (Born 1980-2000)
CORE VALUES		
	• Diversity	• Optimism
	• Thinking globally	• Civic duty
	• Balance	• Confidence
	• Technoliteracy	• Achievement
	• Fun	• Sociability
	• Informality	• Morality
	• Self-reliance	• Street smarts
	• Pragmatism	• Diversity
ON THE JOB ASSETS		
	• Adaptable	• Collective action
	• Technoliterate	• Optimism
	• Independent	• Tenacity
	• Unintimidated by authority	• Heroic spirit
	• Creative	• Multitasking capabilities
		• Technological savvy
MESSAGES THAT MOTIVATE		
	• Do it your way.	• You'll be working with other bright, creative people.
	• We've got the newest hardware and software.	• Your boss is in his/her sixties.
	• There aren't a lot of rules here.	• You and your coworkers can help turn this company around.
	• We're not very corporate.	• You can be a hero here.

Challenge 3

A worldwide worker shortage is developing in all industries. Health care must compete to attract the numbers of hospital workers needed.

STRATEGIC RECOMMENDATION

Attract more workers from the economy at-large by actively pursuing people from the full range of potential sources.

TACTICAL RECOMMENDATION

Reach out to recruit people with early retirement programs from other 24-hours-a-day, 7-days-a-week jobs.

Example: Faced with a 10 percent vacancy rate, the Visiting Nurse Service of New York (VNS) has reached out to persuade active and retired firefighters and police officers to consider nursing as a second career, which will require most to return to school. The VNS is working with the New York City Fire Department to get the word out to staff members. They are working on developing similar outreach to the New York City Police and Corrections Departments. Contact Human Resources Vice President Denise Davin at ddavin@vnsny.org or (212) 794-6324.

Example: HCA is giving priority hiring status to qualified soldiers participating in the U.S. Army Recruiting Command's Partnership for Youth Success (PaYS) program. PaYS is a partnership with U.S. industry developed to help the Army attract, train, and deploy young people interested in health care and other careers. Under the HCA agreement, soldiers interested in receiving medical specialty training while in the Army sign a letter of intent to work for HCA when they complete their military term of service. For more information on the PaYS program visit www.armypays.com or contact Thao Nelson at thao.nelson@hcahealthcare.com or at (615) 344-5672.

TACTICAL RECOMMENDATION

Develop re-entry programs for people who have left health care careers but wish to return.

Example: Emory University Hospital hired 18 nurses through its re-entry program for inactive or retired registered nurses. They attend the program full-time for eight weeks after being hired. In exchange for receiving full-time pay and benefits during the training, they agree to work for the hospital for one to two years. The program includes supervised clinical experience three or four days a week plus refresher classroom training in nursing practice and procedures taught by Emory practitioners. Contact program coordinator Marti Wilson at marti_wilson@emoryhealthcare.org or (404) 712-0172.

Example: Gurwin Jewish Geriatric Center in Commack, NY, has an RN refresher program for nurses who have been employed in doctor's offices, schools, or other care settings and wish to work in geriatric-focused long-term care. Participants

are paid while they are in the refresher course, which allows them to quit their other jobs and train for what is usually a position requiring greater knowledge and skills. Contact Assistant Administrator Diane Mertz-Hart at dmertz-hart@gigc.org or (631) 715-2610.

TACTICAL RECOMMENDATION

Seek out those who are unemployed.

Example: University of Texas Medical Branch has a welfare to work program that assists unemployed and under-employed residents of Section 8 housing to become employed or advance their positions in health care. UTMB provides education, skills development, mentoring, and specific job training as well as childcare and transportation for those participating in the program. Contact Kathy Shingleton at kjshingl@utmb.edu or (409) 772-8699, or Annette DiPiero at amdipier@utmb.edu or (856) 489-6501.

Insight: Some hospitals have found "welfare-to-work" programs to be a good source of potential employees.[8]

Example: "HCA Cares" is a joint venture of HCA and the U.S. Department of Labor providing health care career scholarships specifically to workers who have been dislocated since September 11. This $10 million national program is offered for those who want to become RNs, LPNs, radiology technologists, surgical technicians, and certified nursing assistants in return for a work commitment equal to the length of the training. Visit www.hcacares.com or contact Thao Nelson at thao.nelson@hcahealthcare.com or (615) 344-5672.

Example: The employment team at Park Nicollet Health Services carefully monitors the business sections of papers and journals to be aware of downsizing and layoffs in the metropolitan Minneapolis area. They then try to attract affected workers through a number of strategies including asking the HR departments of those companies to include the system in a list of company referrals during outplacement, or partnering with the Minnesota Department of Economic Security to host a job fair. Contact Deidre E. Spalla at dspall@parknicollet.com or (952) 993-1633.

TACTICAL RECOMMENDATION

Work with local community organizations to identify other potential sources of workers.

Example: Bon Secours St. Mary's Hospital in Richmond, VA, has cultivated new avenues for environmental,

dietary, transportation, and other support service staff through public and private agencies. Eight workers have come from a Salvation Army drug and alcohol rehabilitation program. Six environmental services aides were placed through a VA Dept. of Rehabilitative Services program that trains people with mental and physical disabilities to re-enter the workplace. Contact Westin Thiss, Director of Environmental Services, at wes_thiss@bshsi.com or (804) 287-7122.

TACTICAL RECOMMENDATION

Use your current workforce as potential recruiters.

Example: Good Samaritan Community Healthcare in Puyallup, WA, developed a "Star Search" bonus program that gives monetary awards for employees who provide job applicant referrals resulting in new hires. Payment is made to the recruiting employee in two installments. For nursing positions, a one-quarter payment is made at the successful completion of six months of employment by the individual referred, with the balance payable at the successful completion of a full-year of employment. All employees other than human resources staff, executives, department heads, managers, and supervisors are eligible. In its first 18 months, the program had resulted in 128 new hires. Contact Darci Gibson at gibsoda@goodsamhealth.org or (253) 848-6661, ext.1521.

TACTICAL RECOMMENDATION

Offer career development opportunities to your current staff to "grow your own" workforce.

Example: Franklin County Memorial Hospital in Franklin, NE, created a tele-education program with Bryan School of Nursing to advance LPNs to RNs. The hospital provided staff and local school teachers to teach the prerequisite courses needed for enrollment. To date, 10 LPNs in four counties have completed the program successfully. Contact Jerrell Gerdes at jcgerdes@hotmail.com or (308) 425-6221.

Example: The Patient Care Assistant Partnership Program of Holy Family Hospital in Methuen, MA, is a work-study initiative in which nursing assistants are paid their full salary while they are in school to become RNs. Students generally work 24 hours a week at the hospital and receive 16 hours work release time for community college classes. Students get help designing their study program to meet the hospital's needs as well as their own interests. Contact Program Coordinator Jacqui Collins, RN, MSN at jacqui_collins@cchs.org or (978) 687-0156 ext. 2064.

Challenge 4

In a competitive labor market, it is especially important that health care work has a positive image. Many people in our society do not have an accurate image of health careers.

STRATEGIC RECOMMENDATION

Work aggressively to improve the image of health care careers as positive, satisfying, and inspiring.

TACTICAL RECOMMENDATION

Undertake the recommendations in the chapters on Foster Meaningful Work, Improve the Workplace Partnership, and Collaborate with Others to become a more satisfying employer to your current workers.

Insight: The harm to health care's image is almost irreversible when hospital staffers urge others not to work in the field.

TACTICAL RECOMMENDATION

Turn National Hospital Week into a high-visibility event that celebrates hospital workers.

Example: Hospitals in Decatur, IL, join with other organizations/individuals to coordinate a city-wide celebration of nurses during Nursing Week. RNs from around the city, including the hospitals, form a steering committee for the Nurses of Excellence celebration. Award nominees are solicited from employers/friends/physicians. The celebration culminates in a dinner where 300 nurses, as well as physicians and administrators, join together to recognize the work of nurses. Contact Jill Roemer, RN, MSN, Assistant Administrator, Patient Care, St. Mary's Hospital, at jroemer-@smd.hshs.org or (217) 464-2473.

TACTICAL RECOMMENDATION

National and state hospital associations should develop an image campaign for hospital workers, which would serve to increase the morale of current staff and increase public awareness of hospital employment.

Example: The Wisconsin Health and Hospital Association developed a comprehensive statewide image campaign that includes a 30-second paid TV advertisement, magazine advertisement, movie theater advertisement, 6-minute video, web site and brochure. The association trained hospital-based spokespersons and mentors throughout the state to provide community-based people to assist in spreading its positive message. The campaign's web site (www.wihealthcareers.org) provides information about health careers, links to educational opportunities, a list of speakers and mentors, and other resources. The association's members are interested in broadening the campaign to include radio ads, billboard ads, and translation of all materials into Spanish. Contact: Diane Peters at dpeters@wha.org or (608) 274-1820.

TACTICAL RECOMMENDATION

Hospitals with exemplary work environments should showcase their best practices by applying for national recognition. Among the potential venues: Fortune's 100 Best Places to Work; Working Mother's Best Companies for Working Mothers; Baldrige national and state quality awards; and Magnet Hospital status.

TACTICAL RECOMMENDATION

The American Hospital Association and other professional associations should work together and with business and industry to object with one voice to correct negative stereotypes of health care personnel in the media and create a positive image of health professions.

HOSPITALS RECOGNIZED AS EXEMPLARY EMPLOYERS

Baldrige National Quality Award Finalists, December 2001

Baptist Hospital, Inc., Pensacola, FL

SSM Health Care, St. Louis, MO

Hospitals Recognized in Fortune Magazine's 100 Best Places to Work, February 2002

Baptist Health Care, Pensacola, FL

East Alabama Medical Center, Opelika, AL

Griffin Hospital, Derby, CT

St. Luke's Episcopal Health System, Houston, TX

Magnet Hospitals, January 2002

Aristocrat Berea Skilled Nursing & Rehabilitation Facility, Berea, OH

Aurora Health Care, West Allis, WI

Avera McKennan Hospital & University Health Center, Sioux Falls, SD

Baptist Hospital of Miami, Miami, FL

Bayfront-St. Anthony's Health Care, St. Petersburg, FL

Catawba Memorial Hospital, Hickory, NC

Cedars-Sinai Medical Center, Los Angeles, CA

Children's Memorial Medical Center, Chicago, IL

Fox Chase Cancer Center, Philadelphia, PA

Hackensack University Medical Center, Hackensack, NJ

High Point Regional Health System, High Point, NC

INOVA Fairfax Hospital, Falls Church, VA

James A. Haley Veterans' Hospital, Tampa, FL

Jersey Shore Medical Center, Neptune, NJ

Jewish Hospital, Louisville, KY

Long Island Jewish Medical Center, New Hyde Park, NY

Mayo-Rochester Hospitals, Rochester, MN

Medical Center of Ocean County, Point Pleasant, NJ

Middlesex Hospital, Middletown, CT

The Miriam Hospital, Providence, RI

Morristown Memorial Hospital, Morristown, NJ

Mount Sinai Medical Center, Miami Beach, FL

North Carolina Baptist Hospital of Wake Forest University, Winston-Salem, NC

North Shore University Hospital, Manhasset, NY

Poudre Valley Health System – Poudre Valley Hospital, Fort Collins, CO

Providence St. Vincent Medical Center, Portland, OR

Riverview Medical Center, Red Bank, NJ

Robert Wood Johnson University Hospital, New Brunswick, NJ

St. Francis Medical Center, Trenton, NJ

Saint Joseph's Hospital of Atlanta, Atlanta, GA

St. Joseph's Regional Medical Center, Paterson, NJ

St. Luke's Episcopal Hospital, Houston, TX

St. Luke's Regional Medical Center, Boise, ID

St. Peter's University Hospital, New Brunswick, NJ

University of California, Davis Medical Center, Sacramento, CA

University of Kentucky Hospital, Lexington, KY

University of Washington Medical Center, Seattle, WA

West Boca Medical Center, Boca Raton, FL

Hospitals Recognized in Working Mother Magazine's Best Companies for Working Mothers, October 2001

Baptist Health Systems, Coral Gables, FL

Bon Secours Richmond Health System, Richmond, VA

BryanLGH Medical Center, Lincoln, NE

INOVA Health System, Fairfax, VA

Northwestern Memorial Hospital, Chicago, IL

Novant Health, Winston-Salem, NC

1 U.S. Census Bureau, Internal Release Data April 2, 2001 and National Sample Survey of Registered Nurses 2000, HRSA, Bureau of Health Professions, Division of Nursing.

2 Center for Health Workforce Studies, University of Albany, State University of New York using data from the Bureau of Labor Statistics and Current Population Survey.

3 Center for Health Workforce Studies, University of Albany, State University of New York using data from the Bureau of Labor Statistics and Current Population Survey.

4 Department of Labor. Workforce in the 21st Century. June 2001.

5 H. Gleckman, "Immigrants: A Rich Stew in the Melting Pot," Business Week, August 24-31, p 76.

6 R. Zemke, C. Raines, and B. Filipczak, Generations at Work. New York City: American Management Association, 2000.

7 H. Taylor, "Older Workers: A Valuable Resource for the Workplace," in Working Through Demographic Change. Boulder, Colorado: Human Resource Services, Inc, 2001, pp. 8-9.

8 Welfare to Work. Strategies for Health Care Work Force Development. Irving, TX: AHA Health Foundation, 2001.

Collaborate With Others

The hospital workforce crisis is pervasive. While individual hospitals can and must take action, the crisis cannot be overcome without collaboration among hospitals and many other organizations.

This collaboration must co-exist with the competition spurred by payment system and marketplace changes that have forced hospitals to become competitive business entities. To survive financially, they have had to compete with each other for market share, managed care contracts, and clinical resources.

Unfortunately, that sense of competition has extended to the workforce arena. As hospitals grapple with an immediate and growing workforce shortage, many are competing with each other for staff by offering hiring bonuses and other short-term incentives. Unfortunately, these actions simply move the shortage around, consume scarce financial resources, and do nothing to fix it.

The Commission firmly believes that collaboration, not competition, is the key to solving the growing workforce shortage. The fact is, the work that must be done is too overwhelming for most hospitals to accomplish on their own, and partnerships are essential. These partnerships may be among hospitals in local communities or through efforts coordinated by regional, state, or national associations.

But collaboration goes beyond the hospital community to educational institutions: local schools, community colleges, technical schools, and universities. It includes financial and intellectual investment by corporations and foundations, as well as working with government and a variety of community and national organizations focused on youth, including faith-based organizations.

The call for collaboration goes beyond moderating the ill effects of competing for workers. It serves another purpose: to bring to a manageable level the enormous complexity and cost of actions that must be initiated and accomplished to solve the shortage.

The Challenges

Challenge 1
Hospitals cannot improve the workforce shortage alone.

Challenge 2
Associations need to use the collective resources of their members and others to support solutions to the workforce shortage.

Challenge 3
Students need to be exposed to health careers early in their education.

Challenge 4
Hospitals need to improve relations with the colleges and universities that train the workforce.

Challenge 5
Hospitals need to work with community, faith-based, and youth organizations that influence career decisions.

Challenge 6
Hospitals need to seek resources from corporations and foundations to help address the workforce shortage.

Challenge 7
Hospitals need to make use of existing government resources such as those available through the 1998 Workforce Investment Act.

Challenge 8
Workers need to be retained in the hospital field as a whole.

Challenge 1

Most hospitals are complex but relatively small entities. Individual hospitals do not have the capacity or resources to improve the workforce shortage alone.

Insight: Nearly half of all hospitals have fewer than 100 beds and fewer than 500 employees representing many occupations.[1]

STRATEGIC RECOMMENDATION

Collaborate with other hospitals on a local or regional basis to be more effective at specific workforce recruitment and retention initiatives.

TACTICAL RECOMMENDATION

Collaborate with other hospitals to provide ongoing employee development and worker advancement opportunities.

Example: The Hospital Consortium Education Network (www.hospitalconsort.org) is a network of more than 50 hospitals in Northern California that collaborate to provide education and training to its employees. The hundreds of courses offered include specialized clinical certification, new graduate orientation, NCLEX review, RN refresher, leadership/management, and many continuing education programs for a variety of health care providers. Participating hospitals report benefits in cost-effectiveness, consistency, and quality, and a wide range of opportunities available to employees including hospital-specific programs and opportunities for hospital educators to teach for the network. Contact Rebecca Petersen at becky@hospitalconsort.org or (650) 696-7863.

TACTICAL RECOMMENDATION

Collaborate with other hospitals to create labor pools that can be deployed to alleviate temporary staffing shortages.

Example: Lakes Region General Hospital, a 117-bed hospital in Laconia, NH, and Franklin General Hospital, a 50-bed hospital in Franklin, NH, have teamed up to solve staffing problems in their intensive care units. Together they created "The Nursing Resource Network" (TNRN), a group of six nurses who agree to shuttle between the two hospitals as staffing needs in the ICUs warrant. The program has created a win-win situation, where nurses earn increased compensation and diversified experience while the hospitals maintain adequate staffing levels that ensure patients receive high-quality care. Contact Ellen Garneau, Vice President of Patient Care and Operations at Lakes Region General Hospital, at egarneau@lrgh.org or (603) 524-3211.

Example: Westbrook Health Center and Tracy Area Medical Services, two rural hospitals in southwest MN, have established a successful collaborative that includes sharing of medical and administrative personnel, equipment, and patient and employee satisfaction initiatives.

Sharing personnel and equipment has resulted in better coverage in clinics and emergency rooms, higher utilization of operating rooms, and expanded home health services. Patient and employee satisfaction has improved, and turnover at both hospitals has decreased. This collaborative has been so successful that a third Minnesota hospital, Murray County Memorial, has joined the consortium and is beginning to share personnel and resources. For more information, contact Valerie Sobrack, Director of Community Relations, at sobrackv@siouxvalley.org or (507)-629-3200.

TACTICAL RECOMMENDATION

Collaborate with other hospitals to create, evaluate, and disseminate information about new work models that increase staff productivity and satisfaction, improve clinical outcomes, and advance patient loyalty.

TACTICAL RECOMMENDATION

Collaborate with other hospitals to change the image of health care careers and to influence youth and others toward health care careers within the community.

Example: Nursing 2000 (www.nursing2000inc.org) is a collaborative effort of hospitals, educators, and professional organizations in the Indianapolis area. The program is implemented by 200 RN volunteers and 24 support staff. It is funded by 13 hospitals and health systems. According to post-high school surveys, more than half of the respondents who participated in the organization's 11-year old "A Day in the Life of a Nurse" program – in which about 500 high school sophomores, juniors, and seniors shadow a nurse at one of 13 participating hospitals each year – have gone on to enroll in nursing school. For further information, please email info@nursing2000inc.org or contact Barbara Mitchell, MSN, RN at (317) 574-1325.

Example: Thirty hospitals in Wisconsin are participating in a statewide youth apprenticeship program for high school juniors and seniors that allow students to obtain high school credits while learning skills in a hospital environment. Earned credits are also accepted at participating occupational and technical colleges.

To date, 90 students have become nursing assistants while attending high school. Contact Diane Peters at dpeters@wha.org or (608) 274-1820.

Example: Hospital representatives throughout the state of Pennsylvania are using a sample educational presentation, developed by the Hospital & Healthsystem Association of Pennsylvania, to speak to various audiences about the nursing shortage and to identify collaborative approaches to addressing the shortage. Hospital representatives are also using association-developed publications to conduct outreach to high school, middle school, and elementary school students. Educational tools are available online at www.haponline.org/regulatory/issues/workforce/career/. Contact Lynn Gurski Leighton at lgleighton@haponline.org or (717) 564-9200.

TACTICAL RECOMMENDATION

Collaborate with other hospitals to offer internships, externships, and after-school activities for young people considering health care careers.

Example: Hospitals in Rhode Island offer secondary students, educators, and college students internships in a variety of health-related fields, from medical records to nursing. The hospitals' goal is to offer a centrally located health career information center that will provide students and educators with timely, accurate data on the numerous career paths available. Follow-up activities will include integrated curriculum development and internships. Contact Ruth Ricciarelli at ruthr@hari.org or (401) 274-4274.

Challenge 2

Associations need to use the collective resources of their members and others to find solutions to the workforce shortage.

STRATEGIC RECOMMENDATION

State, regional, and national health care and professional associations should collaborate to support their members' workforce efforts.

TACTICAL RECOMMENDATION

Use associations to collect data and spearhead collaborative workforce planning and development efforts.

Example: The Illinois Hospital Association is working with its membership to provide current data on health care professional shortages. The association is bringing together its members, nursing organizations, allied health organizations, state agencies, and educational institutions and using data to develop a statewide plan for all health care professions. Contact Nancy Krier at nkrier@ameritech.net or (630) 231-0474.

Example: HealthONE Alliance, a non-profit partner of HCA in the Denver-based HealthONE hospital system, has donated $250,000 to create the Colorado Center for Nursing Excellence (CCNE) to address the state's nursing shortage. CCNE will incorporate recruitment, assessment, education, training, retention, career development, and information sharing to increase the number and quality of nurses in the workforce. The grant culminates a one-year study by the Nursing Initiative Work Group, a collaboration of community stakeholders that included the Colorado Health and Hospital Association. CCNE's mission is to build partnerships to enhance the Colorado nursing workforce. Contact Susan Carparelli, CCNE President and CEO, at (303) 322-3515.

Example: In partnership with other health education organizations, Minnesota Hospital and Healthcare Partnership spearheaded a statewide network and collaboration opportunity for hospital leaders and nursing program deans/directors to (1) identify the factors involved with expanding programs and (2) collaboratively work to resolve problematic factors. One product from this initiative is a nursing programs survey that tracks information not collected before, such as nursing student graduate numbers, attrition rates, areas the students come from, where students work after graduation, current employer initiatives to assist nursing students/programs, factors involved to accept more students, and the like. For more information contact Elizabeth Biel at (651) 641-1121.

TACTICAL RECOMMENDATION

Use associations as a communications linchpin to disseminate workforce data, resources, priorities, and needs among hospitals, professions, government, and the public.

Example: The Florida Hospital Association has two broad-based committees devoted to the workforce; one is exclusively for nurses, the other for allied health professionals. Working through its committees and a dedicated web site, the association serves as a resource center for workforce issues. FHA provides information about workforce shortages, future needs, downloadable PowerPoint presentations, a list of hospital and association actions, and links to hospital jobs throughout the state. Visit www.fha.org/nursinghr or contact Cathy Allman at cathya@fha.org or (407) 841-6230.

Example: The New Jersey Hospital Association's Center for Nursing and Health Careers serves as a one-stop resource for students, guidance and career counselors, health care professionals, and executives. The Center partners with critical stakeholders and provides information about: undergraduate and graduate health educational programs; health careers as second career options; LPN-to-RN mobility programs; sources for financial aid, including tuition assistance, loan forgiveness, and scholarships; refresher courses for those choosing to re-enter the profession; and professional certification and licensure. The Center also provides tools to aid in the recruitment of students to health care professions. Visit www.njharecruitment.com or contact Barbara Tofani at btofani@njha.com or (609) 275-4028.

Example: Minnesota Hospital and Healthcare Partnership created an alliance with Minnesota Organization of Leaders in Nursing to coordinate and implement an initiative that fosters, enhances, and strengthens a positive hospital work environment. The project's goal is to create a workplace environment for nursing practice that enhances respect and recognition of staff while improving care delivery. The project will initially focus efforts in five pilot sites, located in both rural and urban areas, and findings will be applicable to hospitals facing similar worker morale issues. For more information contact Laurel Anderson at (651) 641-1121.

TACTICAL RECOMMENDATION

Use state, regional, and national hospital associations to create multi-year strategic workforce development plans. Have the associations bring together hospitals, educators, and representatives from the health professions.

Example: Arizona Hospital and Healthcare Association is launching the Campaign for Caring, a five-year initiative to attract and support more qualified and increasingly dedicated nurses and health care professionals in the state. Its operational goals are to: (1) increase awareness and attractiveness of health care careers to youth and others of varying age, cultural, and ethnic composition; (2) create and nurture partnerships between academia and delivery systems; and (3) promote best practices and workplace innovation. Contact Fran Roberts, RN, PhD at froberts@azhha.org or (602) 445-4300.

Challenge 3

Children in primary and secondary schools are the future hospital workforce. Students need a solid educational foundation and an early awareness of health profession opportunities.

STRATEGIC RECOMMENDATION

Develop ongoing partnerships with local school systems to increase the pool of potential health care workers.

TACTICAL RECOMMENDATION

Work with local primary and secondary school leaders to improve the effectiveness of basic education.

Example: INTEGRIS Health of Oklahoma City, working with local and state school officials and juvenile authorities, has transformed the Western Village Elementary School from having the lowest test scores and highest truancy rate in the area to the first charter elementary school in the state. INTEGRIS oversees all aspects of managing the school, including staffing, financial management, and curriculum development, which includes a hands-on, arts-integrated curriculum. It also established an After-School Academy, Saturday School, and Summer Academy where students learn life skills and study in a safe, supervised environment. The school's Positive Directions Mentoring program recruits volunteers from the community to work one-on-one with students for an hour each week to establish caring adult relationships and improve their reading, math, and language skills. Contact program director Tobi Campbell at camptl@integris-health.com or (405) 951-2119.

Insight: People interested in health care careers need a good basic education that includes core math and science curricula.

Insight: Primary and secondary education is failing to prepare many students with the skills needed by hospitals. "Despite widespread efforts to boost reading achievement, the gap between fourth-grade minority and white students is wider than ever. And the divide between the highest- and lowest-performing students in reading has widened, as well." Those are the findings of the 2000 National Assessment of Education Profession, the "nation's report card." The latest results show that the average score for the nationally representative sample of students was 217 on a 500-point scale – the exact same score for tests administered in 1992 and 1998. Overall, slightly less than one-fourth of students were considered "proficient" – the standard set for all children. About 37 percent did not even meet the basic level.[2]

TACTICAL RECOMMENDATION

Work with secondary school teachers, counselors, and parents to help students understand and consider the wide array of possibilities for career opportunities in health care.

Example: Twenty-five bed Blue Hill Hospital in Maine has added a staff position that makes health care presentations to K-12 students in the county's schools. Contact Andrea McGill-O'Rourke, Manager of Health Profession Development and Career Advancement, at amcgillorourke@emh.org or (732) 374-2836, ext. 1008.

Example: The New Vision program at Oswego (NY) Hospital attracts some of the area's top high school seniors. College-bound high school students who are interested in a health care career gain clinical experience in a wide range of hospital departments during the year-long program, gaining credits in health occupations while satisfying English and social studies requirements. The program, which has graduated 77 students in four years, has helped students discover health careers they did not know existed. Contact the Oswego County Board of Cooperative Educational Services, at www.oswegoboces.org or Ron Graham at (315) 343-7899

Example: As part of the hospital's Workforce Supply Strategy, Northwestern Memorial Hospital in Chicago has developed a partnership with the Chicago Public Schools in creating and developing a Medical and Health Careers Academy. This career academy works with two high schools in which their students are immersed in studies focused on health care topics, skills, and career options. Northwestern Memorial actively participates on the Medical and Health Careers Academy Advisory Board, Curriculum Subcommittee and Best Practices Subcommittee. Annually, the students visit the hospital and are educated on and given an in-depth look at critical areas in the hospital. Employees of the hospital volunteer their time to speak in the classrooms about their jobs and health care. The Medical and Health Careers Academy students are integrated into Northwestern Memorial's other youth programs, including the Medical Explorers and student summer internships. Contact: Maria Lin, Program Manager, NM Academy & Human Resources, at mlin@nmh.org or (312) 926-9531.

Example: The Hospital Youth Mentoring Program is a nationwide initiative that links neighborhood middle school and high school youth with hospital staff who volunteer as mentors. The pilot program was supported by the Commonwealth Fund and administered by The Johns Hopkins Hospital. Fifteen urban medical centers from across the country initially participated in the pilot phase. Twelve have institutionalized their programs and continue to recruit mentors and students. To get in touch with Network members and receive materials and membership information, as well as direct assistance on program design and implementation, contact Deborah Knight-Kerr, Program Manager, at dkkerr@jhmi.edu or (410) 955-1488.

Challenge 4

Community colleges and universities educate most of the hospital workforce. However, the link between these educational institutions and hospitals is too often weak or non-existent.

STRATEGIC RECOMMENDATION

Invest time, people, and funding to build strong, supportive relationships with area colleges and universities.

TACTICAL RECOMMENDATION

Work with local community colleges and universities to develop creative, nontraditional approaches to educating students.

Example: The Cleveland Clinic Health System and Cleveland State University are collaborating to offer an accelerated nursing track. Beginning in May 2002, the program will allow adults with a bachelor's degree in another field to receive a bachelor of science in nursing in 15 months after completing prerequisite courses. The Cleveland Clinic will provide clinical rotations for students and funding to hire additional faculty and staff at the school. Contact Ron Mickler, Jr. at Cleveland State at nursing.adviser@csuohio.edu or (216) 687-3810.

Example: Archbold Medical Center in Thomasville, GA, is partnering with nursing schools for a fast-track nursing program (four semesters). The schools agree to pay the students' tuition and fees, the hospitals agree to pay the students a living wage while they attend school, and the students commit to working at the hospital for three years. Contact Vice President of Human Resources Zach Wheeler at zwheeler@archbold.org or (229) 228-2744.

TACTICAL RECOMMENDATION

Offer scholarships, internships, and externships to students enrolled in health care programs.

Example: Tri-County Hospital in Lexington, Nebraska, provides student loan repayment and scholarships for physical therapists, respiratory therapists, medical technologists, radiology technicians, and nurses. Contact Cal Hiner, Administrator, at tch_calh-@webco.net or (308) 324-8303.

TACTICAL RECOMMENDATION

Collaborate with local educational organizations to provide professional development opportunities for current employees.

Example: Northern Virginia Community College through its "Practice Plus" program provides professional development opportunities to Northern Virginia Regional Hospitals. These include INOVA Health System, Reston Hospital Center, and Virginia Hospital Center Arlington. The programs, whose intent is to offer career-long learning and vocational pathways, provide classes at nontraditional times to best serve the schedules of working adults. Contact: Patti DeiTos at pdeitos@nvcc.vccs.edu or (703) 323-4109.

Example: The Greater New York Hospital Association (GNYHA) and its members are collaborating with SEIU Local 1199 in New York City and the City University of New York to provide

nursing education opportunities to union members. In the interest of expanding nursing programs that are available to union employees, GNYHA has hosted meetings with seven associate degree schools of nursing affiliated with GNYHA members and the 1199/SEIU Employment-Training and Job Security Fund. A Training Fund representative has visited each school and reviewed the curriculum. Negotiations have focused on issues of admission requirements, courses that will be accepted for transfer credit, tuition payment policies, course scheduling, and student support services. The SEIU Local 1199 Training and Upgrading, Job Security and Planning and Placement Funds are being used to fund these education positions. Contact GNYHA's Patricia O'Brien at obrien@gnyha.org or (212) 246-7100 or SEIU's Debbie King at dking@1199etjsp.org or (212) 494-0524.

Example: North Shore University Hospital, a member of the North Shore-Long Island Jewish Health System, is partnering with Nassau Community College to create an on-site degree program for nonlicensed employees who want to become RNs. The current nursing staff marketed the program to other employees, and 300 applications were received. Some employees were provided with remedial training for basic skills before they could meet the requirements for the RN program. The system pays for tuition up front and does not require a continuing employment commitment from the student workers. Contact system CNO Maureen White at mwhite-@lij.edu or (718) 470-7817.

TACTICAL RECOMMENDATION

Partner with local educational institutions to address their shortages of faculty, clinical training sites, and other capacity barriers.

Example: Funded through a competitive grant from the U.S. Department of Health and Human Services, Wyoming Valley Health Care System is teaming up with the University of Scranton to expand the nurse anesthetist training program. Lack of

clinical space had been a barrier to increasing enrollment. Through this partnership, Wyoming Valley's four rural hospitals will serve as clinical training sites for the program. Contact Barbara Halesey at bhalesey@wvhcs.org or (570) 552-8800.

Example: Through joint efforts of the Greater Houston Partnership and the Gulf Coast Workforce Board, area hospitals committed 25 FTEs to serve as faculty for local colleges and universities to allow an increase in nursing school enrollment of 218 for Fall 2001. Contact Karen Love at karen.love@theworksource.org or (713) 499-6651.

Insight: Nearly 40 percent of nursing schools that report they do not accept all qualified applicants into entry level baccalaureate nursing programs point to faculty shortages as a reason.[3]

TACTICAL RECOMMENDATION

Partner with educational institutions to identify realistic expectations for new graduate competencies and readiness to work.

Example: Members of the North Carolina Hospital Association work with multiple organizations, including the Allied Health Council, the North Carolina Center for Nursing, and the SHEPS Center, to meet current and future needs of health care professionals and their employers. Collectively, these organizations are addressing education practice collaboratives and the potential for competency-based education to meet student and employer needs. Contact Kathy Heilig at (919) 677-2400.

TACTICAL RECOMMENDATION

Organize local or regional roundtables of hospital executives, educators, and clinical leadership to provide feedback links between education and employers.

Example: The Kentucky Hospital Association created the Center for Health Care Professions to focus on the education and re-education of Kentucky's health care workforce and the attraction and retention of practitioners. The Center works with hospital administrators, deans of education systems, licensing boards, hospital clinicians, and professional associations to coordinate workforce development efforts throughout Kentucky. Contact Joy M. Knight at jknight-@kyha.com or (502) 426-6220.

Example: The Dallas-Fort Worth Hospital Council brings together the deans of community colleges and non-private colleges with hospital leaders to discuss educational and employment needs. The Council also works with colleges and hospitals individually and facilitates funding from the state and hospitals for student slots. Contact John Gravas at johng@dfwhc.org or (972) 719-4900.

TACTICAL RECOMMENDATION

The American Hospital Association should partner with associations of community colleges and universities to develop a checklist of characteristics for successful hospital-education training partnerships.

TACTICAL RECOMMENDATION

The American Hospital Association should convene a national roundtable of hospital executives, educators, and clinical leaders to create links between educators and health care employers.

Challenge 5

Hospitals need to work with community, faith-based, and youth organizations that influence career decisions.

STRATEGIC RECOMMENDATION

Partner with local community organizations to attract students to careers in health professions.

Example: More than 32,000 young men and women participate in Health Careers Exploring, a Learning for Life program, where students age 14-20 learn about a wide range of health careers. Working with employers in over 960 schools and health-related organizations, these youth learn and explore careers in an array of different fields, including physician/surgeon, nursing, radiology, dentistry, veterinary medicine, and more. Contact Peggy Chestnut at (972) 580-2433 or pchestnut@netbsa.org.

Challenge 6

Hospitals need to seek resources from corporations and foundations to help address the workforce shortage.

STRATEGIC RECOMMENDATION

Partner with corporations and foundations to attract students to health care careers.

Example: Johnson & Johnson has launched a multi-year, $20 million media and scholarship effort to attract people to careers in the nursing profession. Johnson & Johnson is partnering with hospitals and nursing organizations in major U.S. cities to produce galas that honor health professionals and raise scholarship funds. Contact Doug Michels, President of J&J Health Care Systems Inc., at (732) 562-3598.

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Challenge 7

The 1998 Workforce Investment Act created a state and local-based system to connect employment, education, and training services to better match workers to labor market needs. In general, health care has not made use of these programs.

STRATEGIC RECOMMENDATION

Partner with local workforce development councils.

Example: Pierce County, Washington's three largest non-govermental employers - MultiCare, Good Samaritan, and Franciscan Health Systems - are partnering with local schools, labor, and the Pierce County Workforce Development Council to increase the pool of candidates for health services occupations. The Council was established as part of Washington's implementation of the Workforce Investment Act; $300,000 has been allocated for the health care initiative. Efforts include development of four career paths to help facilitate entry into health care or career movement forward, and expanding and enhancing training capacity. Contact Jody Lynn Smith, MultiCare's Director of Employee Relations and Employment, at jody.smith@multicare.org or (253) 403-1372.

Insight: For information and tools on the Workforce Investment Act (WIA), as well as updates on state-based WIA implementation plans, visit http://usworkforce.org/

Challenge 8

When retention is viewed only as an individual hospital issue, opportunities to retain workers in health care across a career may be missed. Workers need to be retained in the hospital field as a whole.

STRATEGIC RECOMMENDATION

Work with other hospitals to retain workers in health care when they move to another community or seek a new job.

TACTICAL RECOMMENDATION

Broaden the concept of upward mobility to develop career paths that cross institutions but remain within health care.

Example: Many New York hospitals participate in a job security program established as part of SEIU Local 1199's Employment-Training and Job Security Fund. The program guarantees employment opportunities to laid-off employees. If another participating facility has a job opening in the same category as a laid-off employee, the worker is guaranteed a 30-day probationary employment period at that other hospital. Binding arbitration is offered to employees who are not hired after their probation period. Contact SEIU's Debbie King at dking@1199etjsp.org or (212) 494-0524.

TACTICAL RECOMMENDATION

Explore the advantages and disadvantages of benefits portability and seniority portability to help retain employees within the health care delivery field.

Example: The development of the Teachers' Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) in higher education increased the retention of faculty in colleges and universities.

TACTICAL RECOMMENDATION

Have hospital associations develop benchmark retention data for their members to monitor improvements in field-wide retention.

1 Health Forum LLC, Hospital Statistics 2002. Chicago: Health Forum, 2002, Table 2.

2 School Library Journal, May 2001, p. 20.

3 American Association of Colleges of Nursing, 2000-2001 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of College of Nursing, 2001.

Build Societal Support

Hospitals are the very core of the nation's health care infrastructure. In addition to being open all hours of every day to care for the sick and injured, hospitals benefit the nation and its communities in many other ways. They subsidize care for those who cannot pay. They improve community health status by providing community health services, such as health fairs, free vaccinations, and smoking cessation programs. In many communities, the hospital is the largest employer and a major part of the economy. Hospitals also maintain the capability to respond to a variety of disasters. September 11 and its aftermath served as a stunning reminder that America's hospitals are places of great comfort and assurance when times are toughest.

The ability of each hospital to continue serving its community is directly related to its ability to maintain an adequate number of motivated and well-trained caregivers and support personnel. Thus, the hospital worker shortage threatens communities as a whole as well as the individuals who are a part of them.

Society, through government and community action, needs to make sure the health care system has the infrastructure and resources to meet community needs. Its responsibilities to hospitals go beyond providing adequate reimbursement for patients who are part of public programs.

The American public, businesses, and governments all count upon a well-staffed hospital system. Just as hospitals must make changes to address the workforce shortage, the broader society must also understand and support the actions that must be taken to eliminate the shortage of caregivers and support personnel.

Because society faces needs and demands in many arenas, hospitals cannot assume that their problems are highly visible to government, business, or the local community. Hospital leaders must work in each of these arenas to increase societal understanding and build support for addressing hospital challenges, including workforce challenges.

The recommendations in this chapter address actions that governments, business, and educational systems must undertake, with the participation and support of hospital leaders and state, regional, and national hospital associations. While this chapter does not contain specific case examples, the Commission recognizes and applauds the advocacy agendas that already are in place to address many of the challenges cited.

The Challenges

Challenge 1

Society needs to increase its investment in the health care system.

Challenge 2

Hospitals need resources to invest in new technologies that improve work and patient care.

Challenge 3

Excessive regulations and standards that result in paperwork and fragmentation are a major source of worker dissatisfaction.

Challenge 4

Many employment policies favor retirement and discourage creativity in retaining older workers.

Challenge 5

Unique training and licensure of health professions hinder interdisciplinary solutions to the workforce shortage.

Challenge 6

There is a need for better data about workforce supply and demand.

Challenge 1

Society's continuing underinvestment in its health care system severely hinders hospitals' abilities to solve the workforce shortage.

STRATEGIC RECOMMENDATION

Government programs, private funders, and all insurance payers must financially support the development of well-trained caregivers and support personnel.

TACTICAL RECOMMENDATION

All payers should support at least the clinical education component of training in the health professions through scholarship and reimbursement of hospital-sponsored efforts.

TACTICAL RECOMMENDATION

Medicare should provide support for the clinical education of nurses, pharmacists, and therapists that compares more closely with the support now provided for physician education.

TACTICAL RECOMMENDATION

Government programs should provide the neccessary resources to ensure the education of future generations of caregivers including adequate Medicare funding for graduate medical education and adequate Public Health Service funding for health professions education and training.

STRATEGIC RECOMMENDATION

Government programs, private funders, and all insurance payers must provide hospitals with payments that reflect the real labor market costs required to attract and retain an appropriate number and mix of qualified staff.

TACTICAL RECOMMENDATION

Medicare should annually provide a full marketbasket increase to cover the labor costs incurred by hospitals and other health care providers.

TACTICAL RECOMMENDATION

Government programs must provide for additional funding when hospital labor costs rise due to the enactment of legislation or the implementation of regulations that raise wage rates or increase required numbers of workers.

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Challenge 2

New technologies that improve work compete for scarce hospital resources with new diagnostic and treatment technologies expected by the community. Hospitals need resources to invest in both kinds of technology.

STRATEGIC RECOMMENDATION

Both government and private sector support are needed to allow hospitals to introduce the essential technology that facilitates hospital work improvement efforts.

TACTICAL RECOMMENDATION

AHA should convene the health care delivery community, information system vendors, and payers to explore the development of standardized information systems for health care delivery based on common IT platforms.

TACTICAL RECOMMENDATION

The federal government and the private sector should fund demonstration projects that explore how to integrate technology to support hospital work design efforts.

TACTICAL RECOMMENDATION

The federal government should provide financial incentives to spur hospital investment in information technology. The private sector should also financially support such investment.

TACTICAL RECOMMENDATION

Third party payers must reimburse hospitals for the worker training expenses that are required by the introduction of technology. Ongoing training is key to making new technology successful in the work environment.

Challenge 3

Excessive regulations and standards that result in paperwork and fragmentation are a major source of hospital worker dissatisfaction.

STRATEGIC RECOMMENDATION

Government regulations should minimize the administrative burden imposed on health care workers.

TACTICAL RECOMMENDATION

The Centers for Medicare and Medicaid Services should conduct a comprehensive review of its rules, regulations, and instructions with the objective of minimizing paperwork and documentation burdens imposed on hospital workers.

TACTICAL RECOMMENDATION

Regulations and accreditation standards established to ensure the quality and safety of hospital services should focus on desired outcomes, while leaving hospitals free to organize tasks in the most efficient and satisfying way for patients and workers.

TACTICAL RECOMMENDATION

Information required for payment should not impose special-purpose recordkeeping. Documentation requirements should be by-products of routine hospital operating and information systems so that worker time presently devoted to special purpose documentation can be returned to the care of patients.

STRATEGIC RECOMMENDATION

Regulations that govern specific practices of individual occupations should not impede the delivery of the right care, at the right time, by the right person, in the right setting.

TACTICAL RECOMMENDATION

A national research and demonstration project should be established to develop new practice acts that reflect the education, skills, and competencies of today's caregivers.

TACTICAL RECOMMENDATION

Hospitals should develop new models of accountability for measuring and documenting worker competencies that can be used to work with regulators toward regulatory improvements.

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Challenge 4

Many employment policies favor retirement and discourage creativity in retaining older workers.

STRATEGIC RECOMMENDATION

Government and employer-based retirement policies need to change to encourage older workers to remain in the workforce.

TACTICAL RECOMMENDATION

ERISA should be revised to eliminate provisions that limit employers' ability to offer flexible work arrangements to older workers.

Insight: Limitations on in-service pension distributions may hinder employers' efforts to implement phased retirement programs.

Insight: The Social Security tax in particular discourages spouses from continuing to work. Because the spouse is entitled to half of their mate's benefit whether the spouse works or not,[1] there is little or no additional benefit to be gained for Social Security taxes the spouse pays.

TACTICAL RECOMMENDATION

The payment formulas of defined benefit retirement plans should be revised so that they no longer discourage partial employment at the end of a career.

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Challenge 5

Unique training and licensure of health professions hinder interdisciplinary solutions to the workforce shortage.

STRATEGIC RECOMMENDATION

Education in the health professions and allied health professions needs to emphasize interdisciplinary training to facilitate team-based approaches to patient care.

TACTICAL RECOMMENDATION

A national summit on education in the health careers should be held to develop coordinated and collaborative education and training programs.

TACTICAL RECOMMENDATION

Professional societies and associations need to work together and support new approaches to patient care.

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Challenge 6

The lack of ongoing systematic data collection and analysis about health care workforce supply and utilization contributes to cyclical periods of worker shortages and oversupply.

STRATEGIC RECOMMENDATION

Provide consistent resources for workforce data collection, analysis, and publication to avoid future shortages and oversupply.

TACTICAL RECOMMENDATION

The federal government should support the development of an ongoing, multi-disciplinary baseline of information on health care training and employment.

TACTICAL RECOMMENDATION

Hospital associations should support national and state funding for data collection on workforce supply and projections for the future, and contribute data from their members.

TACTICAL RECOMMENDATION

The hospital community should seek an appointment to the U.S. Department of Labor's Council on the 21st Century Workforce.

TACTICAL RECOMMENDATION

Foundations should expand their workforce initiatives beyond studies of educational programs and individual professions, to study workforce issues from the perspective of the employer and work teams.

1 A. Reynolds, "Work Opportunities and Incentives for Older Americans," in Working Through Demographic Change. Boulder, Colorado: Human Resource Services, Inc, 2001, p.81.

Commission Conlusions

Hospitals face both short- and long-term shortages of caregivers and support personnel. These workforce shortages reflect fundamental changes in population demographics, career expectations, work attitudes, and worker dissatisfaction. The shortages will not disappear with either the current or the next economic downturn. They require immediate and sustained action by hospitals, associations, schools and universities, foundations, businesses, and governments. Without such action, our society will face a major crisis in health care.

The members of the AHA Commission on Workforce represent a wide range of backgrounds, professions, and perspectives from inside and outside the hospital field. Together, we have developed recommendations that must be acted upon if our nation is to prevail over current and looming workforce shortages. We have titled our report IN OUR HANDS because we believe that hospital leaders must be the driving force behind the changes and initiatives necessary to prevent workforce shortages from becoming a national and local health care crisis.

While technology, market share, financial performance, physician recruitment, and facilities management are all important to a hospital's success, they fail to include an important truth: health care is always about people caring for people.

For decades, human resources has been treated as just one of many hospital support departments. This must change. Human resources in today's hospital must be seen as central to the organization's strategic direction, equally important as finance and program development. Every hospital and health system needs an effective, long-term human resource strategy that includes input and a partnership with hospital workers.

The recommendations in this report are not a menu from which hospitals, the professions, or society-at-large may make particular selections. Rather, the recommendations are a comprehensive set of actions that are intended to be simultaneously addressed with sustained attention and commitment.

The recommendations provide an opportunity to make fundamental improvements in health care organizations and in the work of both caregivers and support personnel. Now is the time for hospitals and health systems to make the changes that address the current shortage and that can help prevent a long-term crisis. The changes are not easy ... but they are necessary.

The Commission will view its work as successful only if the recommendations of this report are implemented. The recommendations can be the foundation of a strong, sustained, and committed local and national effort to truly build a thriving health care workforce and ensure the health of our communities.

Appendices

1 COMMISSION CHARGE 82

2 AHA COMMSSION ON WORKFORCE FOR HOSPITALS & HEALTH SYSTEMS, COMMISSIONER BIOGRAPHIES 83

3 HISTORICALLY BLACK COLLEGES AND UNIVERSITIES 86

4 HISPANIC SERVING INSTITUTIONS 88

Appendix 1

COMMISSION CHARGE

To develop bold goals and actionable recommendations to:

- **Increase recognition that human resources are a core, strategic resource of hospitals;**
- **Fully value and invest in workforce recruitment, retention, and development;**
- **Expand interest in health care careers and educational programs;**
- **Make hospitals and health systems "employers of choice."**

Appendix 2

AHA COMMISSION ON WORKFORCE FOR HOSPITALS & HEALTH SYSTEMS COMMISSIONER BIOGRAPHIES

CHAIR

Gary A. Mecklenburg is president and chief executive officer of Northwestern Memorial HealthCare in Chicago. Previously, he held various leadership positions at hospitals in Wisconsin and California. Mecklenburg is immediate past chairman of the American Hospital Association and chairman of the Association's Commission on Workforce for Hospitals and Health Systems.

MEMBERS

G. Rumay Alexander, MSN, EdD, RN, is president and CEO of The Roxie Company in Nolensville, Tennessee. Previously, she was senior vice president for clinical and professional practices at the Tennessee Hospital Association, providing guidance on clinically related, nursing, diversity in the workplace, public education, and community health status issues. Alexander is a member of the board of directors of the American Organization of Nurse Executives, a subsidiary of the American Hospital Association, and has a master's degree in nursing.

Dr. Jacquelyn M. Belcher is president of Georgia Perimeter College in Atlanta. In addition to serving on the Governor's Education Reform Study Commission, she has chaired and participated on national councils relating to leadership, business development, and high school and collegiate education. Belcher holds multiple degrees in nursing, a juris doctorate, and a business credential.

Maureen Bisognano is executive vice president and chief operating officer at the Institute for Healthcare Improvement (IHI) in Boston and has dedicated her career to improving health care quality. Prior to joining IHI, she was senior vice president of The Juran Institute, where she supported the implementation of total quality management concepts in health care settings. Earlier, she served as chief executive officer of Massachusetts Respiratory Hospital in Braintree, Massachusetts.

Leo P. Brideau is president and chief executive officer of Columbia-St. Mary's Hospital in Milwaukee, Wisconsin. Previously, he was president of Strong Health Regional Network, chairman of the Health Care Association of New York State, and an assistant professor of community and preventive medicine at the University of Rochester School of Medicine and Dentistry. Brideau is a member of the American Hospital Association's board of trustees and executive committee.

Sandra Bennett Bruce is president and chief executive officer at Saint Alphonsus in Boise, Idaho. She has held this position at Mercy General Health Partners, Muskegon, Michigan, and Berrien General Hospital in Berrien Center, Michigan. Bruce is chairperson of the Idaho Hospital Association and active on the American Hospital Association's region five policy board.

Peter W. Butler is the former president and chief executive officer of the Methodist Health Care System in Houston. He has also served in leadership positions at the Henry Ford Health System in Detroit and Rush-Presbyterian-St. Luke's Medical Center in Chicago. Butler was chairman of the American Hospital Association's Commission on Workforce for Hospitals and Health Systems from April to November 2001.

Stephen W. Daeschner, PhD, is superintendent of the Jefferson County Public Schools in Louisville, Kentucky. He began in this position in 1993 and he holds one of the longest tenures of any large-city superintendent in the nation. In the course of his career, he has held various positions at the teacher, principal, and superintendent levels.

Karen Davis, PhD, is president of The Commonwealth Fund in New York City. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health, where she also held an appointment as professor of economics. Davis served as deputy assistant secretary for health policy in the Department of Health and Human Services and was the first woman to head a US Public Health Service agency.

Laura Easton, RN, is senior vice president of hospital operations and chief nursing executive of Caldwell Memorial Hospital in Lenoir, North Carolina. She has held various nurse executive positions at hospitals in New York, North Carolina, and New Hampshire. Easton is a district representative for the North Carolina Organization of Nurse Executives and was a Kellogg Foundation Public and Health Policy Fellow at the U.S. House of Representatives.

Antonio Flores, PhD, is the president and chief executive officer of the Hispanic Association of Colleges and Universities in San Antonio, Texas. Flores has extensive experience in higher education administration and policy analysis. He has worked at both community colleges and universities, where he has taught and conducted research on higher education issues.

Mary E. Foley, MS, RN, is president of the American Nurses Association in Washington, DC. She was previously employed for 19 years at Saint Francis Memorial Hospital in San Francisco, as both chief nurse executive and a medical-surgical staff nurse. Foley was also a part-time clinical faculty member at San Francisco State University School of Nursing and was the faculty adviser for the student nurses association at the school.

John C. Gavras is president of the Dallas-Ft. Worth Hospital Council. He has held this position for 25 years and previously worked for the Hospital Financial Management Association and the Oklahoma Hospital Association. Gavras has served on American Hospital Association advisory boards, as an adjunct professor at several Texas-based universities, and was the first recipient of the highest non-physician award presented by the Dallas County Medical Society.

Raymond Grady, FACHE, is president and chief executive officer of Evanston Hospital and serves as president of the hospitals and clinics division for Evanston Northwestern Healthcare in Evanston, Illinois. He served as the American Hospital Association's representative to the Accrediting Commission on Education and Health Services Administration for seven years, including a stint as chairman. He is currently a member of the Illinois Hospital and HealthSystems Association's board of directors.

Joyce Grove Hein is chief executive officer at Phelps Memorial Health Center in Holdrege, Nebraska. She has held various leadership positions at hospitals in Louisiana, Mississippi, and Minnesota. Hein holds a master's degree in human and health services from St. Mary's College in Winona, Minnesota.

Troy Hutson, RN, JD, is director of legal and clinical policy at the Washington State Hospital Association in Seattle. Hutson began his health career as a medic in the Army, then attended nursing school and received a commission into the Nurse Corps. After the military, he served as a staff nurse, charge nurse and case manager prior to becoming an attorney.

Anita Langford, RN, MS, is vice president of continuing care at the Johns Hopkins Bayview Medical Center (JHBMC) in Baltimore, Maryland. Prior to her current position, she was senior director for long-term care at JHMBC, director of nursing, and then administrator at the Johns Hopkins Geriatrics Center. Langford has served as an adjunct faculty member at the George Washington University and as a member of various American Hospital Association committees.

Karen L. Miller, RN, PhD, FAAN, is dean and professor of the University of Kansas School of Nursing and the University of Kansas School of Allied Health. Prior to these appointments, she was vice president of nursing and clinical services at The Children's Hospital in Denver, and associate professor at the University of Colorado Health Sciences Center. In 2000, Miller was appointed to the National Advisory Council on Nurse Education and Practice of the Health Resources and Services Administration, part of the Department of Health and Human Services.

Jack A. Newman, Jr., is executive vice president of Cerner Corporation in Kansas City, Missouri. Prior to joining Cerner, he served as partner-in-charge of the National Health Care Strategy Practice for KPMG LLP. Newman is a national speaker on the financial and quality of care benefits associated with health care information technology.

Robert J. Parsons, PhD, is a trustee for the Urban South Region of Intermountain Health Care and a professor of economics at Brigham Young University in Provo, Utah. He was a member of the American Hospital Association's Committee on Governance, which helps develop orientation programs for trustees nationwide. Parsons is also active in the Utah Hospital Association and has conducted research published in a number of health care journals.

Limaris L. Perez is assistant practice administrator at Phillips Family Practice in New York City. When she joined the commission, Perez was completing a degree at Pennsylvania State University in health policy and administration. She has completed an internship at the Hospital and Healthsystem Association of Pennsylvania and participated in that organization's statewide patient safety collaborative project.

Randolph B. Reinhold, MD, is chairman of the department of surgery and director of surgical services and the operating room at the Hospital of St. Raphael in New Haven, Connecticut. In addition to holding the rank of professor of surgery at Yale University and Tufts University Schools of Medicine, he is the author of over 50 articles and book chapters. Reinhold has served on several medical staffs in the New England area, including Tufts New England Medical Center, New England Deaconess, and Massachusetts General Hospital.

Robert Riney is senior vice president and chief human resources officer at the Henry Ford Health System in Detroit. Before his appointment, Riney served as vice president for human resource organizational effectiveness and design and vice president for human resources at Henry Ford Wyandotte Hospital. He is chair-elect of the American Society for Healthcare Human Resources Administration, a personal membership group of the American Hospital Association, and previously served as head of that society's diversity task force.

Fran Roberts, PhD, RN, is the vice president for professional services at the Arizona Hospital and Healthcare Association in Phoenix, Arizona. At that organization, she is also the director of the Healthcare Institute and the project director of a Robert Wood Johnson Foundation grant on nursing workforce development titled "Colleagues in Caring." She previously served as executive director of the Arizona State Board of Nursing and is currently first vice president of the Arizona Nurses' Association.

Bruce J. Rueben is president of the Minnesota Hospital and Healthcare Partnership in Minneapolis, Minnesota. Previously, he was president of the Maine Hospital Association and held leadership positions at the Virginia Hospital and Healthcare Association. Rueben also served as a vice president of the Diamond Healthcare Corporation.

Edward S. Salsberg is the executive director of the Center for Health Workforce Studies at the School of Public Health at the University at Albany of the State University of New York in Resselaer, New York. The Center conducts a wide range of studies on the supply, demand, need, distribution, and use of health personnel in New York and nationally. The Center is one of five centers nationally with a federal cooperative agreement for health workforce studies.

Andrew L. Stern is president of the Service Employees International Union (SEIU) in Washington, DC. SEIU has 1.5 million members – making it the largest and fastest growing union in the AFL-CIO. It is the largest union of workers in hospitals, nursing homes, and health care, representing more than 110,000 nurses and 20,000 doctors.

Sara J. White, RPh, FASHP, is director of pharmacy at Stanford Hospital and Clinics and a clinical professor at the University of California – San Francisco School of Pharmacy. She was an associate director of pharmacy and professor at the University of Kansas Medical Center previously. White is a past president of the American Society of Health System Pharmacists.

EX OFFICIO

Richard J. Davidson has been president of the American Hospital Association in Washington, DC, and Chicago since 1991. He came to the post after 22 years at the Maryland Hospital Association, where he was its first president. Davidson serves on the boards of the Health, Research and Educational Trust and the International Hospital Federation and is a founding director of the Institute for Diversity.

Sister Mary Roch Rocklage, RSM, is chairperson of the board of directors of the Sisters of Mercy Health System in St. Louis, Missouri. Trained as a nurse, Rocklage held various nursing and administrative positions before becoming president of the health care system from 1986 to 1999. Currently, she is chairperson of the American Hospital Association's board of trustees and serves as an adjunct professor of health care administration at St. Louis University and Washington University.

Appendix 3

HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

ALABAMA

Alabama A & M University
Alabama State University
Bishop State Community College
Bishop/Carver Campus
Concordia College
Drake Technical College
Lawson State Community College
Gadsden State C.C. - Valley Street Campus
Miles College
Oakwood College
Shelton State C. C. - Fredd Campus
Stillman College
Talladega College
Trenholm State Tech. College
Tuskegee University

ARKANSAS

Arkansas Baptist College
Philander Smith College
University of Arkansas/Pine Bluff

DELAWARE

Delaware State College

DISTRICT OF COLUMBIA

University of the District of Columbia

FLORIDA

Bethune-Cookman College
Edward Waters College
Florida A & M University
Florida Memorial College

GEORGIA

Albany State College
Clark Atlanta University
Fort Valley State College
Morehouse College
Morris Brown College
Paine College
Savannah State College
Spelman College

KENTUCKY

Kentucky State University

LOUISIANA

Dillard University
Grambling State University
Southern Univ A & M College
Southern Univ/New Orleans
Southern Univ/Shreveport
Xavier University

MARYLAND

Bowie State University
Coppin State College
Morgan State University
Univ of Maryland/Eastern Shore

MICHIGAN

Lewis College of Business

MISSISSIPPI

Alcorn State University
Coahoma Junior College
Hinds Junior College - Utica Campus
Jackson State University
Mary Holmes College
Mississippi Valley State University
Rust College
Tougaloo College

MISSOURI

Harris-Stowe State College
Lincoln University

NORTH CAROLINA

Barber-Scotia College
Bennett College
Elizabeth City State Univ
Fayetteville State University
Johnson C. Smith University
Livingstone College
North Carolina A & T State Univ
North Carolina Central Univ
St. Augustine's College
Shaw University
Winston-Salem State University

OHIO

Central State University
Wilberforce University

OKLAHOMA

Langston University

PENNSYLVANIA

Cheyney State University
Lincoln University

SOUTH CAROLINA

Allen University
Benedict College
Claflin College
Denmark Technical College
Morris College
South Carolina State University
Voorhees College

TENNESSEE

Fisk University
Lane College
LeMoyne-Owen College
Tennessee State University

TEXAS

Huston-Tillotson College
Jarvis Christian College
Paul Quinn College
Prairie View A & M University
Saint Philip's College
Southwestern Christian College
Texas College
Texas Southern University
Wiley College

U. S. VIRGIN ISLANDS

University of the Virgin Islands

VIRGINIA

Hampton University
Norfolk State University
Saint Paul's College
Virginia State University
Virginia Union University

WEST VIRGINIA

Bluefield State College

Appendix 4

HISPANIC SERVING INSTITUTIONS

Non-profit, accredited colleges, universities or systems where total Hispanic student enrollment constitutes a minimum of 25% of the total enrollment, including full-time and part-time students whether at the undergraduate or graduate level.

ARIZONA

Arizona Institute of Business and Technology - Mesa
Arizona Institute of Business and Technology- Phoenix
Arizona Western College
Central Arizona College
Cochise College
Estrella Mountain Community College
Phoenix College
Pima Community College
South Mountain Community College

CALIFORNIA

Allan Hancock College
Bakersfield College
California State University-Bakersfield
California State University-Dominguez Hills
California State University-Fresno
California State University-Los Angeles
California State University-Monterey Bay
California State University-Northridge
California State University-San Bernardino
California State University-Stanislaw
Cerritos College
Chaffey Community College
Citrus College
College Of The Desert
College Of The Sequoias
Compton Community College
D-Q University
Don Bosco Technical Institute
East Los Angeles College
El Camino College
Fresno City College
Fullerton College
Gavilan College
Hartnell College
Heald College School Of Business-Salinas
Heald College School Of Business-San Jose
Heald College School Of Business-Stockton
Heald College School Of Business And Tech-Hayward
Heald College School Of Business And Technology-Fresno
Heald College School Of Business And Technology-Milpitas
Imperial Valley College
Kelsey-Jenney College
Long Beach City College
Los Angeles City College
Los Angeles County Medical Center School Of Nursing
Los Angeles Harbor College
Los Angeles Mission College
Los Angeles Trade Technical College
Los Angeles Valley College
Merced College
Mount Saint Marys College
Mount San Antonio College
Oxnard College
Palo Verde College
Pasadena City College
Porterville College
Reedly College
Rio Hondo College
San Bernardino Valley College
San Diego City College
Santa Ana College
Southwestern College
The National Hispanic University
University Of Laverne
Ventura College
West Hills Community College
Whittier College
Woodbury University

COLORADO

Adams State College
Community College Of Denver
Otero Junior College
Pueblo Community College
Trinidad State Junior College

FLORIDA

Barry University
Caribbean Center For Advanced Studies-Miami
Florida International University
Miami-Dade Community College
Saint John Vianney College Seminary
Saint Thomas University
Trinity International University
University Of Miami
Valencia Community College

ILLINOIS

City Colleges Of Chicago-Harry S Truman College
City Colleges Of Chicago-Malcolm X College
City Colleges Of Chicago-Richard J Daley College

City Colleges Of Chicago-Wilbur Wright College
Morton College
Northeastern Illinois University
Saint Augustine College

KANSAS

Seward County Community College

MASSACHUSETTS

Urban College of Boston

NEW JERSEY

Englewood Hospital Medical Center
Hudson County Community College
Jersey City State College
Passaic County Community College
Saint Peter's College

NEW MEXICO

Albuquerque Technical Vocational Institute
Eastern New Mexico University-Roswell Campus
Luna Vocational Technical Institute
Mesa Technical College
New Mexico Highlands University
New Mexico Junior College
New Mexico State University-Carlsbad
New Mexico State University-Dona Ana
New Mexico State University-Grants
New Mexico State University-Main Campus
Northern New Mexico Community College
Santa Fe Community College
University of New Mexico Los Alamos Campus
University of New Mexico-Main Campus
University of New Mexico-Taos Education Center
University of New Mexico-Valencia County Branch
Western New Mexico University

NEW YORK

Boricua College
College of Aeronautics
College of Mount Saint Vincent
CUNY Borough Of Manhattan Community College
CUNY Bronx Community College
CUNY City College
CUNY Hostos Community College
CUNY John Jay College Criminal Justice
CUNY La Guardia Community College
CUNY Lehman College
CUNY New York City Technical College
Mercy College

PUERTO RICO

American University of Puerto Rico-Bayamon
American University of Puerto Rico-Manati
Atlantic College
Bayamon Central University
Caribbean Center for Advanced Studies
Caribbean University-Bayamon
Caribbean University-Carolina
Caribbean University-Ponce
Caribbean University-Vega Baja
Colegio Tecnologico Del Municipio De San Juan
Colegio Universitario Del Este
Conservatory Of Music Of Puerto Rico
Escuela de Artes Plasticas de Puerto Rico
Humacao Community College
Inter American University of Puerto Rico
Instituto Tecnologico de Puerto Rico-Manati
Instituto Tecnologico de Puerto Rico-Ponce
Instituto Tecnologico de Puerto Rico-Rio Piedras
Inter American University of Puerto Rico-Aguadilla
Inter American University of Puerto Rico-Arecibo
Inter American University of Puerto Rico-Barranquitas
Inter American University of Puerto Rico -Bayamon
Inter American University of Puerto Rico -Fajardo
Inter American University of Puerto Rico -Guayama
Inter American University of Puerto Rico -Metro
Inter American University of Puerto Rico -Ponce
Inter American University of Puerto Rico -San German
Pontifical Catholic University of Puerto Rico-Arecibo
Pontifical Catholic University of Puerto Rico -Guayama
Pontifical Catholic University of Puerto Rico-Mayaquez
Pontifical Catholic University of Puerto Rico -Ponce
Universidad Adventista de Las Antillas
Universidad Central del Caribe
Universidad del Turabo
Universidad Metropolitana

Universidad Politecnica de Puerto Rico
University of Puerto Rico-Aguadilla Regional College
University of Puerto Rico-Arecibo Campus
University of Puerto Rico –Bayamon Tech University College
University of Puerto Rico -Carolina Regional College
University of Puerto Rico –Cayey University College
University of Puerto Rico -Humacao University College
University of Puerto Rico -La Montana Regional College
University of Puerto Rico -Mayaquez
University of Puerto Rico -Medical Sciences Campus
University of Puerto Rico -Ponce Technical University College
University of Puerto Rico -Rio Piedras Campus
University of Sacred Heart

TEXAS

Coastal Bend College
Del Mar College
El Paso Community College
Howard County Junior College District
Laredo Community College
Mountain View College
Odessa College
Our Lady of the Lake University-San Antonio
Palo Alto College
Saint Edwards University
San Antonio College
South Plains College
South Texas Community College
Southwest Texas Junior College
St Mary's University
St Philip's College
Sul Ross State University
Texas A & M International University
Texas A & M University-Corpus Christi
Texas A & M University-Kingsville
Texas Southmost College
Texas State Technical College-Harlingen
The University of Texas-Pan American
The University of Texas at Brownsville
The University of Texas at El Paso
The University of Texas at San Antonio
The University of Texas Health Science-San Antonio
The University of Texas of the Permian Basin
University of Houston-Downtown
University of Saint Thomas
University of Incarnate Word
Victoria College

WASHINGTON

Heritage College

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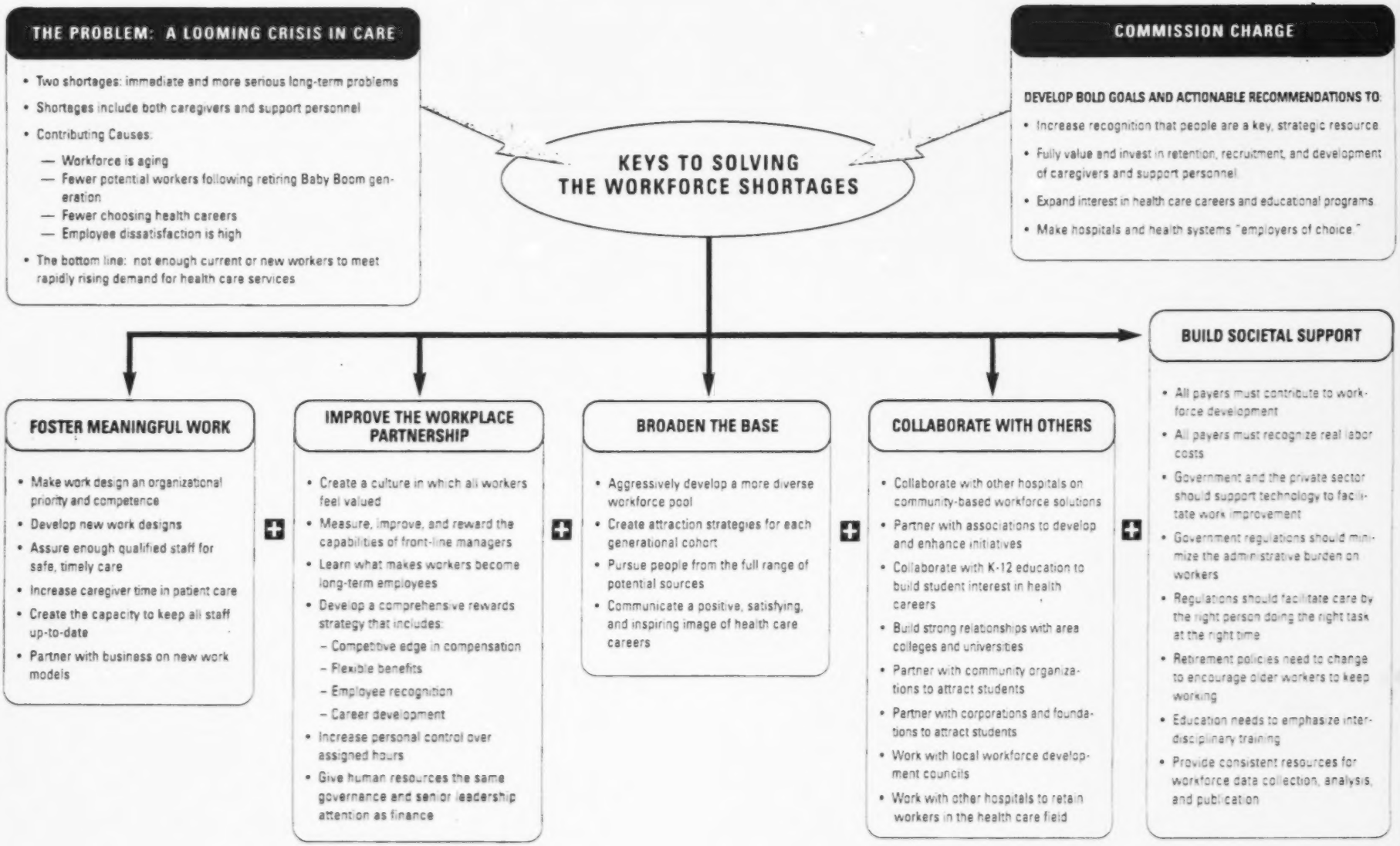
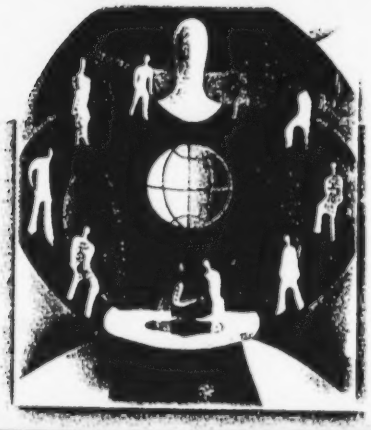
The Workforce Strategy Map


THE PROBLEM: A LOOMING CRISIS IN CARE
• Two shortages: immediate and more serious long-term problems
• Shortages include both caregivers and support personnel
• Contributing Causes:
— Workforce is aging
— Fewer potential workers following retiring Baby Boom generation
— Fewer choosing health careers
— Employee dissatisfaction is high
• The bottom line: not enough current or new workers to meet rapidly rising demand for health care services
KEYS TO SOLVING THE WORKFORCE SHORTAGES
COMMISSION CHARGE
DEVELOP BOLD GOALS AND ACTIONABLE RECOMMENDATIONS TO:
• Increase recognition that people are a key, strategic resource
• Fully value and invest in retention, recruitment, and development of caregivers and support personnel
• Expand interest in health care careers and educational programs
• Make hospitals and health systems "employers of choice."
FOSTER MEANINGFUL WORK
• Make work design an organizational priority and competence
• Develop new work designs
• Assure enough qualified staff for safe, timely care
• Increase caregiver time in patient care
• Create the capacity to keep all staff up-to-date
• Partner with business on new work models
IMPROVE THE WORKPLACE PARTNERSHIP
• Create a culture in which all workers feel valued
• Measure, improve, and reward the capabilities of front-line managers
• Learn what makes workers become long-term employees
• Develop a comprehensive rewards strategy that includes:
– Competitive edge in compensation
– Flexible benefits
– Employee recognition
– Career development
• Increase personal control over assigned hours
• Give human resources the same governance and senior leadership attention as finance
BROADEN THE BASE
• Aggressively develop a more diverse workforce pool
• Create attraction strategies for each generational cohort
• Pursue people from the full range of potential sources
• Communicate a positive, satisfying, and inspiring image of health care careers
COLLABORATE WITH OTHERS
• Collaborate with other hospitals on community-based workforce solutions
• Partner with associations to develop and enhance initiatives
• Collaborate with K-12 education to build student interest in health careers
• Build strong relationships with area colleges and universities
• Partner with community organizations to attract students
• Partner with corporations and foundations to attract students
• Work with local workforce development councils
• Work with other hospitals to retain workers in the health care field
BUILD SOCIETAL SUPPORT
• All payers must contribute to workforce development
• All payers must recognize real labor costs
• Government and the private sector should support technology to facilitate work improvement
• Government regulations should minimize the administrative burden on workers
• Regulations should facilitate care by the right person doing the right task at the right time
• Retirement policies need to change to encourage older workers to keep working
• Education needs to emphasize interdisciplinary training
• Provide consistent resources for workforce data collection, analysis, and publication



The Workforce Strategy Map

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